

**AN EXPLORATORY STUDY OF  
SOUTH AFRICAN CLINICAL PSYCHOLOGISTS' OPINIONS  
OF THE INSANITY DEFENCE.**

**Submitted in partial fulfillment  
of the requirements for the degree of Masters of Social Science  
in Clinical Psychology, in the Department of Psychology,  
University of KwaZulu-Natal, Pietermaritzburg.**

Unless indicated to the contrary, this is the original work of the author.

**PHILIPPA IGEA STYLES**

March 2007

## **ABSTRACT**

This quantitative exploratory study surveyed 64 South African clinical psychologists' opinions of the insanity defence. Clinical psychologists are increasingly becoming meaningful contributors to the judicial process in South Africa with regard to criminal incapacity. It is therefore considered important to canvas their opinions. To the author's knowledge this is the first research on psychologists' opinions of the defence in South Africa, possibly internationally. A standardized Likert scale developed by Skeem and Evans-DeCicco (2004) to gauge jury views on the insanity defence in the United States was used as the data collection tool. This research employed an overall correlational research design. Due to heterogenous variances the more liberal assumptions of non-parametric tests were used to extrapolate findings. The bulk of opinion rested in the moderate to ambivalent support ranges, with few strongly positive or negative opinions of the insanity defence. Significant results suggest that female psychologists, regardless of race, showed less support of the insanity defence than their male counterparts. Furthermore, those whose primary therapeutic orientation was psychodynamic had less support than those who practiced other modalities. However, a disappointingly small sample size and low reliability of the scale makes the generalisability of the results tentative, and thus further research is needed to verify these findings.

## ACKNOWLEDGMENTS

Many people have assisted me with this dissertation of whom I am enormously grateful.

My research supervisor, Professor Douglas Wassenaar for reading, editing and advising on numerous drafts. Doug, many thanks for your patience and guidance, I have learnt a lot from you and am much in your debt.

My friends, most especially, Shevonne Rautenbach for her patient assistance in explaining statistical concepts and editing and, Charlene McIntosh and Fatima Vawda-Thomas for their support.

Ray Ramdas, for assistance with statistics and relevant texts.

My Masters class of 2005, for providing a warm and interactive environment to learn the fledgling art of psychology in.

The Psychology Department of UKZN (Pietermaritzburg) and Midlands Hospital Complex for being phenomenal training institutions exemplified by dedicated staff who provide a rigorous, ethical and exemplary education.

The anonymous respondents of my research, for which this dissertation would not have been possible.

Julia Hulley and Simon Taylor, for being supportive and encouraging siblings.

My husband, David Styles, for his endless patience, love and support; and guidance not only with editing, but appreciation for the English language.

Pippa Styles

March 2007

## TABLE OF CONTENTS

	Page
Abstract	ii
Acknowledgements	iii
Table of Contents	iv
List of Tables	v
List of Figures	vi
List of Abbreviations Used	vi
<b>1 INTRODUCTION</b>	<b>1</b>
<b>2 LITERATURE REVIEW</b>	<b>4</b>
2.1 HISTORICAL OVERVIEW	4
2.1.1 A brief history of the insanity defence, with an emphasis on South Africa	4
2.1.2 Early history of psychology and its interaction with the law	7
2.2 LEGAL ASPECTS	10
2.2.1 The insanity defence as a controversial construct	10
2.2.2 Insanity as a legal term	10
2.2.3 Criminal capacity	14
2.2.4 Pathological versus non-pathological criminal incapacity	15
2.2.5 Automatism	18
2.2.6 Procedural aspects of establishing insanity	19
2.2.7 Disposition of defendants	21
2.2.8 Judicial management of State Patients	23
2.3 PSYCHOLOGY AND LAW	24
2.3.1 Competing paradigms within the psycholegal milieu	24
2.3.2 Psychology in the forensic arena.	26
2.3.3 Forensic psychology in South Africa	27
2.3.4 The role of psychologists in assessing mental state for criminal courts	28
2.3.5 Perceptions of psychologists as expert witnesses	29
2.4 THE INSANITY DEFENCE AS AN ARTIFACT OF VIOLENT CRIME	30
2.4.1 Mad' versus bad	31
2.4.2 Szasz's argument against the insanity defence	34
2.5 PUBLIC PERCEPTIONS OF THE INSANITY DEFENCE	35
2.5.1 Research on jurors' attitudes to the insanity defence	35
2.6 SUMMARY	40
<b>3 METHODOLOGY</b>	<b>42</b>
3.1 AIMS AND RATIONALE	42
3.2 RESEARCH QUESTIONS	42
3.3 RESEARCH DESIGN	43

3.4	INSTRUMENTS	44
3.4.1	Demographic Data Sheet	44
3.4.2	Insanity Defense Attitude-Revised Scale (IDA-R)	44
3.5	PROCEDURE	46
3.6	QUALITY OF RESPONSE	47
3.7	SAMPLE	48
3.8	ANALYSIS OF DATA	48
<b>4</b>	<b>RESULTS</b>	52
4.1	DESCRIPTIVE CHARACTERISTICS OF SAMPLE	52
4.2	RELIABILITY OF IDA-R SCALE	66
4.3	RESEARCH QUESTION ONE	67
4.4	RESEARCH QUESTION TWO	70
4.5	RESEARCH QUESTION THREE	74
4.6	RESEARCH QUESTION FOUR	78
4.7	INCIDENTAL QUALITATIVE ASPECTS OF THIS RESEARCH	79
4.8	SUMMARY OF RESULTS	81
<b>5</b>	<b>DISCUSSION</b>	84
5.1	An overview of IDA-R scale scores	84
5.1.2	IDA-R scale scores and the demographic variables of gender, race and age	85
5.1.3	IDA-R scale scores and primary area of practice, and therapeutic modality	86
5.1.4	IDA-R scale scores and years of practice and forensic experience, and criminal cases processed	88
5.1.5	Incidental qualitative aspects	89
5.2	LIMITATIONS OF THIS STUDY	90
5.3	MAIN CONCLUSIONS	92
5.4	RECOMMENDATIONS FOR FUTURE RESEARCH	94
	<b>REFERENCE LIST</b>	96
	<b>APPENDICES</b>	99
Appendix A	Demographic Data Sheet	99
Appendix B	Insanity Defense Attitude Scale-Revised (IDA-R)	100
Appendix C	Invitation letter to psychologists to participate in research	103
Appendix D	IDA-R scoring key	104
	<b>LIST OF TABLES</b>	
Table 1	Cross-tabulation of race by gender	52
Table 2	Means and standard deviations of race by age	53

Table 3	Frequencies of practice and forensic experience for clinical psychologists	55
Table 4	Frequencies of psychologists who have processed criminal cases	56
Table 5	Cross-tabulation of gender by highest degree obtained	60
Table 6	Frequencies of year in which highest degree was obtained	61
Table 7	Frequency representation of graduating universities (ranked)	62
Table 8	Frequencies and interpretation of aggregate individual IDA-R scale scores	69
Table 9	Mann-Whitney U Test between gender and IDA-R scale scores	70
Table 10	Mann-Whitney U Test mean ranks of IDA-R scale scores by gender	71
Table 11	Chi-Square Test between race and IDA-R scales scores	71
Table 12	Means, standard deviations and ranges of IDA-R scale scores by gender and race	72
Table 13	Pearson Correlations between age and IDA-R Scale Score	73
Table 14	Pearson Correlations between IDA-R scale scores and primary therapeutic orientation	75
Table 15	Means, medians and standard deviations of IDA-R Scale Scores by primary therapeutic orientation	75
Table 16	Pearson Correlations between IDA-R scale scores and primary work setting	76
Table 17	Means, medians and standard deviations of IDA-R Scale Scores by primary work setting	77
Table 18	Pearson Correlations between IDA-R scale scores and experience	78

## LIST OF FIGURES

Figure 1	Age in years by experience: Forensic and practice years, and criminal cases processed	54
Figure 2	Gender by years in practice	57
Figure 3	Race by gender	58
Figure 4	Racial composition of sample by years in practice	59
Figure 5	Number of psychologists by primary work settings	64
Figure 6	Number of psychologists using the following modes of therapy	65
Figure 7	Overall representation of aggregate individual Insanity Defence Scale Scores	68

## LIST OF ABBREVIATIONS USED

ANOVA	Analysis of variance
DCS	Department of Correctional Services
DSM	Diagnostic and Statistical Manual of Mental Disorders
CBT	Cognitive Behavioural Therapy
IDA-R	Insanity Defence Attitude Revised Scale
HPCSA	Health Professions Council of South Africa

MANOVA	Multivariate analysis of variance
MEDUNSA	Medical University of South Africa
OFS	University of the Orange Free State
PMB	Pietermaritzburg
RAU	Rand Afrikaans University
SA	South Africa
SAPS	South African Police Service
SPSS	Statistical Package for Social Sciences
UCT	University of Cape Town
UKZN	University of KwaZulu-Natal
UNISA	University of South Africa
UPE	University of Port Elizabeth
UWC	University of Western Cape
WITS	University of Witwatersrand

## CHAPTER ONE

### INTRODUCTION

This quantitative research project is an attempt to assess clinical psychologists' opinions<sup>1</sup> of the insanity defence in South Africa. It should be noted that the conceptualization of insanity over time is not static, but rather characterized by evolving unidirectional hypotheses which are influenced by the setting of legal precedents (Burchell & Milton, 1997) which in turn is informed by psychiatric lore (Parzen, 2003; Reznek, 1997).

Psychiatric formulations, although enshrined in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM), are subject not only to revision but periodic *völte-fa'ce* due to reformulations of what does and does not constitute mental illness (Reznek, 1997). Thus, the DSM paradoxically serves a rigorous gate keeping function which is simultaneously malleable over time (Reznek, 1997).

Moreover, the malleability of conceptions of insanity is further complicated by the literature. On the one hand, it is asserted that legal definitions of insanity are not clear cut (Kaliski, 2006; Parzen, 2003). On the other hand, psychiatric notions are confounded by multiaxial constellations of clinical syndromes, personality disorders, mental retardation and important contributing psychosocial issues (Reznek, 1997). These assemblages are often untidy, frequently negating neat linear cause and effect relationships in arguing for or against responsibility (Belkin, 2003). Moreover, determining responsibility is further

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<sup>1</sup> The word opinion has been selected because it refers to "views or sentiments, esp. on moral questions, prevalent among people in general" (Sykes, 1978, p. 769). 'Opinion' may at times be used interchangeably with attitudes, views or perceptions.



complicated by the difficulty in predicting dangerousness in mitigation or aggravation of sentencing, more especially with regard to future violent behaviour (Kaliski, 2006).

Allan and Louw (2001) note that the assessment of fitness to stand trial is traditionally the domain of psychiatrists, however, more frequently psychologists are entering the field on these and other forensic aspects, such as the state of mind of the accused at the time of the offense. Therefore, psychiatric and psychological testimony is necessary in assisting the court in deliberating the accused's sanity and, by implication, the sentence (Allan & Louw, 2001), be it incarceration or committal to a psychiatric institution. This potentially places a complicated ethical burden on the psychologist as committal invariably equates to limitless institutionalisation with no parole (Kaliski, 2006), for an accused who may no longer be a danger to society (Reznek, 1997). A prison sentence may indeed be a fairer disposition as it would be confined to a specified period (Burchell & Milton, 2005). This debate becomes even more philosophically complex with contributions from Szasz who asserts that mental illness is a misnomer and that the accused should take responsibility for their actions (cited in Reznek, 1997).

Pioneering research on the insanity defence in the United States of America by Skeem and Golding (2001) was used as the starting point for this project. This is a nomothetic study employing a postal survey of anonymous Likert scale questionnaires developed by Skeem and Evans-DeCicco (2004). The sample for this study was derived through systematic sampling of clinical psychologists registered with the HPCSA (Health Professions Council of South Africa) (Katzenellenbogen, Joubert & Karim, 1999).

Completed questionnaires were analysed through descriptive and inferential statistics to ascertain relationships between variables from which inferences were made (Durrheim, 1999a). An overall correlational design combined with non-parametric tests was used to engender inferential outcomes.

To the author's knowledge, this is the first time that research has been done on (clinical) psychologists' opinions on the insanity defence in South Africa, and indeed internationally. This research is of interest because clinical psychologists are increasingly being used as expert witnesses in South Africa and their opinions on the insanity defence may have a bearing on their assessments and testimonies. Moreover, in an age of international philosophical and ethical deliberations around indefinite psychiatric committal (Kaliski, 2006; Reznick, 1997), it is considered important to prompt debate around the disposition of the criminally insane.

## **CHAPTER TWO**

### **LITERATURE REVIEW**

#### **2.1 HISTORICAL OVERVIEW**

##### **2.1.1 A brief history of the insanity defence, with an emphasis on South Africa**

Most countries in the modern world have some form of the insanity defence enshrined in their legal systems (Parzen, 2003). Although countries in the western world have diverse stances on the insanity defence, they have evolved along similar pathways and thus have shared histories of thinking about criminal responsibility (Reznek, 1997). It is important to note that there are many historical strands to deliberating criminal insanity from the Greek philosophers to biblical times, to the Jewish Talmud, which have coalesced to what we now know as the insanity defence (Parzen, 2003).

Under ancient Roman law, offenders were not incarcerated as they were considered “punished enough by [their] condition without the law adding to [their] punishment” (Prins, 1980, p. 37). Thus, under Roman law, the mentally ill as with young children, were *doli incapax* (lacking criminal capacity) and not held to be responsible for their actions (Burchell & Milton, 1997). This precedent was later held by Roman-Dutch law (Burchell & Milton, 1997) introduced to South Africa by Van Riebeeck *circa* 1652 (Louw, 2006).

The insanity defence can be traced back to the twelfth century in Europe (Sendor, 1986 cited in Parzen, 2003). Under early English law the mentally ill offender was convicted for his/her crime, but simultaneously pardoned from a death sentence (Reznek, 1997). However, prior to 1800 in Britain there were very few institutions for the mentally ill and the criminally insane were invariably incarcerated with offenders (Reznek, 1997). Though, this was later changed when insane asylums were introduced and the mentally ill were 'hospitalised' as opposed to incarcerated (Burchell & Milton, 1997).

Essentially, early legal formulations allowing for criminal capacity sought to establish whether defendants were blameworthy by examining two components: *mens rea* and *actus reus* (Parzen, 2003). *Mens rea* refers to the 'evil' intent behind the criminal act, and *actus reus* to the act itself. However, where a defendant is mentally ill the *mens rea* element is compromised because of the impairment in appreciating the wrongfulness of one's actions (Burchell & Milton, 1997; Parzen, 2003).

One of the earliest modern English legal tests for insanity was the "good and evil test" (*circa* 1716) which had its roots in Christian ideology where "... idiots and Lunatics [were] not punishable by any criminal prosecution whatsoever" (Hawkins Pleas of the Crown cited in Burchell & Milton, 1997, p. 207). The 'good and evil test' was superseded by the 'wild beast test' in 1724 (Burchell & Milton, 1997). This was a relatively crude measure formulated in *R v Arnold*:

... it is not every frantic and idle humour of a man that will exempt him from justice and the punishment of the law... [I]t must be a man that is totally deprived of understanding and memory and doth not know what he is doing,

no more than an infant, than a brute, than a wild beast... (Burchell & Milton, 1997, p. 207).

The wild beast test of insanity held sway for just over a century and was surpassed by assessing whether the defendant could appreciate the difference between right and wrong in 1843 (Burchell & Milton, 1997). This test became known as the M’Naghten Rules and was in essence a refinement of the preceding tests in that it was more secular and significantly broadened and defined mental illness requisite for an insanity plea:

- (1) Every man is presumed to be sane, and to possess a sufficient degree of reason to be responsible for his crimes, until the contrary is proved.
- (2) To establish the defence of insanity, it must be proved that, at the time of committing the act the accused was labouring under such a defect of reason, from disease of the mind, as not to know the nature and quality of his act; or if he did know it, that he did not know he was doing what was wrong.
- (3) A person who labours under a partial delusion only, and is not in other respects insane, must be considered in the same situation as to responsibility as if the facts with respect to which the delusion existed were real (Burchell & Milton, 1997, p. 205).

Thus the M’Naghten Rules acknowledged that insane persons could not be held liable if under the influence of a delusion they were unable to appreciate their criminal actions (Burchell & Milton, 2005). This rule however had a limitation, as it did not allow for those who understood right from wrong but because of their mental illness were unable to control their actions (Burchell & Milton, 2005).

Although South African criminal law has its roots in Roman-Dutch law, it too employed the English M’Naghten Rules which were later refined to include the ‘irresistible impulse

test' in 1899 which allowed for the conative (volitional) element (Burchell & Milton, 2005).

Contemporary "South African criminal law on mental illness arose as a consequence of the acquittal of Demitrios Tsafendas, who assassinated the then Prime Minister, Hendrik Verwoerd in 1964" (Louw, 2006, p. 40). This led to the Rumpff Commission which underpinned the Criminal Procedure Act of 1977. The Rumpff Commission asserted that personality is made up of a dynamic interplay between the psychological and the physical. Moreover, they denoted three integrative categories of healthy mental functioning: cognitive, conative (volitional) and affective functions. Disintegration of any of these components can lead to lack of insight (cognitive), poor impulse control (conative) and inability to regulate emotions (affective) (Louw, 2006). Personality impairment or disintegration derives from one or more of these functions breaking down. Should this be the case, the person affected cannot be held to be criminally responsible. Alternatively, responsibility may be found to be diminished (Louw, 2006). However, Louw (2006) stresses that our law recognises incapacity in terms of cognitive and conative aspects and not the affective or mood component alone. Moreover, the disintegration of the personality refers to a pathological process as opposed to personality disorders.

### **2.1.2 Early history of psychology and its interaction with the law**

The western world's earliest form of forensic psychology is located with the ancient Greeks who philosophically debated the interface between law and psychology (Louw &

Allan, 1998). It was the Greeks who delineated the sources of behaviour in psychology as opposed to divine intervention or the supernatural. However, although issues such as the insanity defence were incorporated into Roman law (Burchell & Milton, 2005), it was only in the 19<sup>th</sup> century that psychology as a discipline began interacting with the law (Louw & Allan, 1998). Louw and Allan (1998) note that it was the rise of psychology as a rigorous scientific discipline which provided a “unique role in law” (p. 234). Moreover, they cite Haward (1981) who details how the psychologist’s “role did not merely supplement that of the psychiatrist, but was an original and unique function” (p. 234).

It has been argued that psychology had its earliest beginnings in shamanism (Finkel, 1988). Eliade (1964) describes shamans as a “small mystical elite [who] not only directs the community’s religious life but, as it were, guards its “soul” (cited in Finkel, 1988, p. 50). Moreover, the shaman is the great specialist in the human soul; he alone “sees” it, for he knows its’ “form” and its destiny” (Finkel, 1988, p. 50).

Shamans could either be “extraordinary and sagacious or a charlatan and trickster” (Finkel, 1988, p. 50). Moreover, that it was a position of power, as shamans had the ability to not only interpret man’s psyche, but be highly influential in societies. However, divisions arose separating different types of healers who specialized in different facets of humankind, on the one hand medical and on the other, the spiritual and psychological (Finkel, 1988). Finkel (1988) states that this is the source of disagreement

around mind and brain, and the focus on physiological explanations of the medical model over more complex psychological explanations.

It was in 1656 that madness was first incorporated under the physicians' domain in Europe with the establishment of the Hospital General, a "semijudicial structure" in Paris (Foucault, 1973 cited in Finkel, 1988, p. 51). With the *lettres de cachet* the King could confine without trial or appeal "a new collection of "social marginals": the poor, the mendicants, spendthrift fathers, prodigal sons, blasphemers, libertines, criminals, and, most of all, the insane" (Finkel, 1988, p. 51). They fell under the purview of physicians who, Finkel argues, became the deliberators of "medicine and morality" (p. 51).

Foucault (1973 cited in Finkel, 1988) notes that the shift from the Renaissance to the Age of Reason had the outcome of 'madness' becoming institutionalized and thus, silenced. Previously, during the Renaissance, there was much debate around insanity which largely dissipated under new ideologies:

In the serene world of mental illness, modern man no longer communicates with the madman...the man of reason delegates the physician to madness, thereby authorizing a relation only through the abstract universality of disease...The language of psychiatry, which is a monologue of reason about madness, has been established only on the basis of such a silence (Foucault, 1973 pp. x-xi cited in Finkel, 1988, p. 51).

Indeed, the morality of the time dictated that those committed were at the mercy of the vicissitudes of the physicians. This meant that punishment and treatment became fused under what Finkel refers to as "the presumption of expertise" (1988, p. 52).



## **2.2 LEGAL ASPECTS**

### **2.2.1 The insanity defence as a controversial construct**

Many authors emphasise that the insanity defence remains, from time immemorial, a highly controversial artifact in judiciaries around the world (Eigen, 1999; Finkel, 1988; Reznick, 1997; Skeem & Golding, 2001). Furthermore, the past two centuries have seen intense debate around this issue, particularly following high profile cases (Skeem & Golding, 2001). Prins (1980) eloquently refers to the grey area between mental disorder and criminal behaviour as “the borderland area” (p. 1). He goes on to argue that causal links between mental illness and criminality are difficult to make. Moreover, debate is not contained within judiciaries but is largely spurred by public outrage (Skeem & Golding, 2001). For South Africa, this was clearly demonstrated following the assassination of Verwoerd (Burchell & Milton, 1997; Louw & Allan, 1998).

### **2.2.2 Insanity as a legal term**

In South Africa, issues of mental health in our criminal courts fall under criminal liability. Insanity is a legal, rather than a psychological or psychiatric, term (Louw, 2006). Therefore, there is a clear distinction in the literature between the legal and medical usage of the term ‘insane’ with the term reserved exclusively for legal purposes (Burchell & Milton, 2005; Reznick, 1997). Reznick (1997) refers to this as exculpatory insanity which is a direct reference to the cognitive status of the accused’s inability to infer right from wrong. This is a sharp departure from psychiatric assessments of patients who may be out of touch with reality due to more complex factors such as delusions or

hallucinations (Kaliski, 2006; Reznick, 1997). Thus, the impaired mental status of the accused will play a role in the evaluation of the accused, but the nomenclature remains in the judicial domain. Therefore, Reznick points out that it is possible to be simultaneously “insane in the medical sense but ... judged legally sane” (1997, p. 17).

The South African Criminal Procedures Act 51 of 1977 allows for the legal defence of insanity as follows:

Mental illness or defect may deprive a person of the capacity to appreciate the wrongfulness of conduct. It may also deprive them of the capacity to control their conduct. A person who suffers from a mental condition that has such an effect is said to be ‘insane’. (Burchell & Milton, 2005, p. 370).

Although the above definition appears straightforward, Kaliski (2006) warns that in South African law the terms ‘mental illness’, ‘mental disorder’ and ‘mental defect’ are not clearly defined. However, for judicial purposes the definition of these terms is broad referring to “a major psychiatric disorder that is known to be associated with significant cognitive and volitional impairments” (Kaliski, 2006, p. 98). The legal literature points out that it is not sufficient for there merely to be evidence of a mental illness, but requires that the incapacity interferes with the ability to discern right from wrong, and impedes the individual’s ability to control his/her actions (Burchell & Milton, 1997). Therefore, “[m]ental illness that impairs only *affective* capacity, or which does not deprive the sufferer of insight or self-control, does not come within the concept of insanity” (Burchell & Milton, 2005, p. 374). Burchell and Milton (2005) state that in South African courts it has been precedent that no general sign or

symptom is prescribed as both necessary and sufficient to qualify as mental disease or defect, as this would be a dangerously narrow prescription (Burchell & Milton, 2005). However, it is important to note that in this context mental illness or defect refers to:

... a pathological disturbance of the accused's mental capacity and not a mere temporary mental confusion which is not attributable to a mental abnormality but rather to external stimuli such as alcohol, drugs or provocation (Burchell & Milton, 2005, p. 375).

Thus, mental illness refers directly to an identifiable 'pathological' disease of the mind, which is usually endogenous in origin (Burchell & Milton, 2005; Louw, 2006). Burchell and Milton (2005) use physical illness as an analogy to infer that the mental illness or defect is involuntary, and therefore the person is not culpable. However, they state that this can frequently be difficult to establish, particularly as the law does not specifically distinguish between organic (brain) or functional (psychological) impairments. What is of importance is that the illness is not the result of 'external' stimuli such as the ingestion of substances (Burchell & Milton, 2005).

Louw (2006) makes the important comment that the definition of mental illness or defect described in the Mental Health Care Act (Act 17 of 2002) is not necessarily binding in a criminal court. This refers to the ultimate issue rule whereby "in court, it is a question of law and not of medicine as to what constitutes a 'mental illness or defect'" (p. 46). This is because medical diagnoses may not meet the statutory requirements of law which is to adduce the guilt of the accused (Louw, 2006). Thus, the court takes cognizance of expert psychiatric or psychological opinion, but is not

bound by this (Africa, 2005; Louw, 2006). Consequently, a criminal case is decided according to the unique characteristics pertaining to it and not according to a “closed list of mental illnesses or defects” (Louw, 2006, p. 47).

The delineation between mental disease and defect rests with its developmental origins (Burchell & Milton, 2005). Mental defect is defined as a “condition where the person has a significantly below average intellectual functioning which is accompanied by significant limitations in several areas of adaptive functioning” (Africa, 2005, p. 392). Mental defect is most usually noticed early in life in terms of the failure to meet developmental milestones inhibiting the attainment of social and behavioural norms. It is inferred that “such individuals have such a low intellectual capacity that they do not have normal cognitive or conative functions” (Rumpff Commission cited in Louw, 2006, p. 48). Forensic practice requires the assessment of the degree of mental retardation in ascertaining the accused’s competence or lack of competency (Louw, 2006). Dementias are normally categorised under mental defect, which refers largely to cognitive/intellectual deficits (Kaliski, 2006)

Mental illness, on the other hand, can occur at any time and may be episodic in nature (Burchell & Milton, 2005). Therefore, criminal responsibility rests not on the illness or defect, but on how these deficits serve to constrain cognitive (insight) or conative (self-control) functioning at the time of the offence (Burchell & Milton, 2005).

Thus, there are four elements to the insanity defence: an unlawful act; combined with evidence of mental illness or defect having a causal effect on the crime at the time of the offence; an illness/defect which predates the offence; and incapacity must be due to lack of cognitive or conative abilities (Louw, 2006). In South Africa, the consequence of a legal verdict of insanity is that the accused will be found “not guilty by reason of mental illness or mental defect” (Burchell & Milton, 1997, p. 396). The disposition of persons so determined will be dealt with in section 2.2.3 below.

### **2.2.3 Criminal capacity**

In South African law one of the mitigating factors against criminal capacity (responsibility) is mental illness or defect. Furthermore, the accused is disposed differently to ‘sane’ criminals (Snyman, 2002 cited in Africa, 2005). Snyman (2002, cited in Kaliski, 2006) states that one can only plead lack of criminal capacity if one has indeed committed the offence. Because South African law assumes criminal capacity, it is the experts’ task to raise evidence which might negate or impair this capacity (Kaliski, 2006). Moreover, criminal responsibility requires that the accused is able to merely ‘appreciate the wrongfulness of the act’ and “not that he should have an understanding of the moral and ethical dimensions of wrongfulness” (Kaliski, 2006, p. 103). In other words, although a person appreciates the wrongfulness of an act, delusions or hallucinations may impair his/her reality testing leading him/her to act contrary to that appreciation, and is thus not found responsible (Kaliski, 2006; Louw, 2006). Consequently, the expert’s role is to determine the extent to which the condition impairs the individual’s ability to control his/her actions.

✿ The test for capacity is a subjective one, deriving from objective evidence collected from the crime (Burchell & Milton, 2005). In South Africa the emphasis is on appreciation, as opposed to knowledge, of the wrongful act (Burchell & Milton, 2005). Appreciation refers to a wider test which, in addition to knowledge, allows for deliberation of the broader ramifications of acting unlawfully, and the ability to act in accordance with moral appreciation. The accused's behaviour is determined with reference to that individual's actions only and not compared to the 'reasonable person' (Louw, 2006), and is thus a subjective test. Of significance, South African law takes into account the impairment of capacity, and not merely the lack of capacity (Burchell & Milton, 2005).

South African law has statutory provisions for the following: "fitness to stand trial, the defence of mental illness, the defence of diminished responsibility, and the defence of non-pathological incapacity" (Africa, 2005, p. 385). This highlights that there are varying degrees of criminal responsibility (Africa, 2005). The two 'insanity' pleas, pathological and non-pathological incapacity, pertaining to this research are outlined below.

#### **2.2.4 Pathological versus non-pathological criminal incapacity**

Under South African criminal law the insanity defence is divided in two and is referred to as pathological incapacity and non-pathological incapacity (Louw, 2006).

Pathological incapacity requires mental illness which is endogenous in origin, as categorized in the DSM (Burchell & Milton, 2005). The mental disorders which have the requisite cognitive and conative impediment giving rise to the possibility of an insanity defence are: mental disorders due to a general medical condition, schizophrenia and other psychotic disorders, mood disorders with psychotic features, and dissociative disorders (Burchell & Milton, 2005). Moreover, “it does not matter whether the illness is temporary or permanent, curable or incurable, or likely to recur or not” (Louw, 2006, p. 47) and causation of the illness is not at issue. Therefore, pathological incapacity refers to an inherent mental illness or defect which is identifiable by a formal psychiatric diagnosis and exists independently of the offence committed (Kaliski, 2006). This infers that the condition is treatable, and that because the symptoms may have driven the motivation for the offence, treatment could plausibly diminish the possibility of re-offending (Kaliski, 2006).

Non-pathological incapacity is the instance where no illness or defect exists but “criminal incapacity that is due to circumstances that are supposedly external to the accused, such as intoxication, provocation and emotional stress” (Kaliski, 2006, p. 105). The assumption behind this defence is that it is an isolated occurrence, is unlikely to occur again and therefore does not threaten public safety. However, Kaliski (2006) refers to this as a largely unfounded assumption. Here psychiatric diagnoses are seldom possible and inferences are made on the individual’s stress state at the time of the offence which may have induced automatism-like behaviour. This defence is often used in murder cases, and largely hinges on the accused’s behaviour following

the offence whereby he/she is bewildered or horrified by his/her actions and seeks help as opposed to attempting to evade responsibility (Kaliski, 2006). Moreover, there is frequently amnesia for the actual offence, but that the accused can give a clear account of preceding and subsequent events including the trigger which induced the 'automatism' (Kaliski, 2006). Therefore, "[n]on-pathological incapacity is in essence a sane automatism defence" whereby the person's actions are not of his/her character and out of his/her control (Kaliski, 2006, p. 106). Furthermore, for this defence to succeed there must be no evidence of pre-meditation. Thus, non-pathological incapacity refers to an exceptional act which is outside the bounds of usual experience thereby disqualifying merely losing one's temper or acting in an enraged state. Additionally, it refers specifically to personality disintegration which affects insight and impulse control, and is thus, "a breakdown in functioning" (Africa, 2005, p. 401).

*S v Chretien* (1981) was the first South African case where "a significant legal space was created to develop the defence of non-pathological incapacity" (Louw, 2006, p. 50). This case introduced the notion of incapacity not being tied to a pathological mental illness, and the possibility that instances of poor insight or self-control could lead to an acquittal (Louw, 2006). Thereafter, defences of provocation or emotional stress became more frequent (Louw, 2006). However, it is argued that these two states are not synonymous, as provocation infers a once-off trigger event, whereas emotional stress is "a build-up of stressful circumstances over a period of time" (Louw, 2006, p. 51). It was in 1985 that the defence of 'temporary non-pathological criminal incapacity' first emerged upon evidence of prolonged emotional stress (Louw, 2006).



However, following two controversial cases where the accused were acquitted even though they were found to be “consciously lacking self-control”, the Supreme Court in 2002 reverted to successful non-pathological defences requiring psychiatric features of sane automatism, and not merely the loss of control (Louw, 2006, p. 52).

### **2.2.5 Automatisms**

Kaliski (2006) delineates the distinction between sane and insane automatisms.

However, he asserts that “...few concepts have caused so much confusion in the courts” (p. 107). In South Africa, sane automatism refers to external factors which impair judgement. For instance, “hypoglycaemia due to overdose of insulin, head injury and intense provocation” (Kaliski, 2006, p. 107). Other examples are “while suffering a blackout... while asleep... under hypnosis... concussion... intoxication... provocation or extreme emotional stress” (Louw, 2006, p. 38). Whereas insane automatism is as a result of internal factors such as inherent illnesses of the brain, the most common seen in South African courts is complex partial epilepsy (Kaliski, 2006).

Complex partial epilepsy has the outward appearance of the person having purposive control over his/her actions (Kaliski, 2006). However, in reality the affected person during a seizure experiences an “electrical storm that overwhelms parts or all of the central nervous system” (Kaliski, 2006, p. 107). Accurate perceptions of the surrounding environment are said to range from being absent or impaired. Moreover, although actions superficially appear purposive, unlike grand mal type epilepsy, the

seizure severely impairs judgement, and amnesia of the event is common (Kaliski, 2006). Therefore, the affected person “would not be able to plan and execute behaviours not previously rehearsed” (Kaliski, 2006, p. 107). The possibility of a fraudulent insanity defence under the guise of complex partial epilepsy is reduced by the aforementioned impaired volitional aspect, and by medical tests which are usually able to detect epilepsy (Kaliski, 2006).

Disposition of the two pleas varies considerably, with insane automatisms resulting in committal as a state patient, and sane automatisms resulting in acquittal (Burchell & Milton, 2005; Louw, 2006). Our courts infer that because sane automatisms are not the result of a chronic illness, there is no disorder to treat and the likelihood of recidivism on this basis is extremely unlikely. Kaliski (2006) refers to the discrepancy in disposition as a ‘curious distinction’ because regardless of the cause of the automatism, it is inferred that brain dysfunction is at the root of both sane and insane automatisms. Moreover, it has been argued that South African courts have difficulty with the existing terminology and are beginning to prefer using the terms ‘automatism not attributable to mental pathology’ and ‘psychogenic automatism’ as opposed to *insane and sane automatism respectively* (Louw, 2006).

#### **2.2.6 Procedural aspects of establishing insanity**

Africa (2005) and Kaliski (2006) note that in South Africa any party in a criminal case can request a psychological assessment of the accused to establish current (fitness to stand trial) or retrospective (criminal capacity at the time of the offence) mental state,

under sections 77 and 78 respectively of the Criminal Procedure Act (51 of 1977).

Furthermore, the burden of proof rests with the party who raises the question of competence or capacity (Kaliski, 2006). At present this is an untested amendment, however (Louw, 2006).

With respect to violent crimes, Section 79 of the Criminal Procedures Act (51 of 1977, amended 1998) requires the appointment of two to three psychiatrists and possibly a clinical psychologist to assess the accused (Kaliski, 2006). In South Africa the appointment of psychiatrists is as follows: a psychiatrist in private practice is appointed for the defense; a psychiatrist in state service represents the superintendent of the hospital, and another hospital psychiatrist assesses the accused to provide an objective opinion (Kaliski, 2006).

Of interest, it is not clear whether the various parties are required to confer. Psychiatrists working for the same hospital invariably produce a co-signed report however, and they are required to address “both requirements of the capacity test, namely *insight* and *self-control*” (Louw, 2006, 50).

In terms of the assessment of mental illness, the accused is remanded in a state psychiatric hospital with forensic facilities for up to a 30 day observation period from which the accused’s mental state is determined (Africa, 2005; Kaliski, 2006).

The process of establishing criminal capacity is a stage-wise process. Firstly, the mental health practitioner establishes whether “the accused suffers from a mental illness, defect, or any other important condition” (Kaliski, 2006, p. 103). Secondly, if a disorder or condition is identified, the severity of the cognitive or volitional impairment needs to be established. And thirdly, the court must determine “whether these impairments influenced the accused’s actions during the commission of the offence” (p. 103). The judicial disposition of defendants is addressed in the following section.

#### **2.2.7 Disposition of defendants**

Burchell and Milton (2005) draw attention to an anomaly in South African law where, should the accused successfully plead non-pathological incapacity, they may be acquitted. However, a plea of pathological incapacity results in institutional committal as a State President’s Patient for an unspecified period. They refer to this state of affairs as a “gross inequality” which hinges on a due process discrepancy where the onus of proof shifts from the prosecution to the accused in instances of non-pathological incapacity (Burchell & Milton, 2005, p. 392). The shift in onus of proof is underpinned by two arguments; firstly that one should be wary of institutional committal if the accused’s insanity is in doubt. And secondly, the accused’s ‘sanity’ is best known, and therefore defended, by the accused. The argument against lessening the burden on the accused is that it may result in an increase in insanity pleas (Burchell & Milton, 2005). Nevertheless the irony of this position is that the prosecution may struggle to dispute the accused’s insanity when it is raised. However, Wilson J states “it is better that a guilty person be found not guilty by reason

of insanity and committed for psychiatric treatment than an insane person be convicted of a crime” (cited in Burchell & Milton, 2005, p. 394). Moreover, the principle behind indefinite committal is regarded as a sufficient deterrent against raising the insanity defence (Burchell & Milton, 2005).

Thus, the evidentiary burden dictates that only insane persons are committed to institutions for an unspecified period of time (Burchell & Milton, 2005). Proving issues of insanity can only occur with the cooperation of the accused. However, this does not cater for the accused under the pathological incapacity plea that was insane at the time of the crime, but has since recovered and is considered to be sane (Burchell & Milton, 2005).

In the instance where the accused is found unfit to stand trial due to mental illness or defect, the court is required to decide on a balance of probabilities whether s/he committed the offence or not (Kaliski, 2006). Louw (2006) states that this is a less onerous task than proof beyond a reasonable doubt. If the offence is not of a violent nature, or the court finds the accused is innocent, s/he may be civilly committed to a psychiatric institution or referred for out-patient treatment (Kaliski, 2006). However, in cases of violent crime combined with evidence of culpability, the accused is remanded in a forensic psychiatric hospital as a state patient under section 42 of the Mental Health Care Act of 2002 (Kaliski, 2006). If the accused is found to have developed a mental disorder subsequent to the committing of the offence and is thus unfit to stand trial, the

case will be remanded for treatment in a psychiatric institution until such time that he is found competent to stand trial (Kaliski, 2006).

The reasoning behind indefinite committals is three fold: public protection, therapeutic treatment of the accused, and punishment (Burchell & Milton, 1997). However, Prins (1980) raises the ethical dilemma that an unspecified period of time may indeed be indefinite, as opposed to a prison term which is predetermined. Therefore, in essence, “because a man may be deemed to be mad, he may be doubly punished” (Prins, 1980, p. 37) and it is questioned whether this is a fair dispensation of justice (Kaliski, 2006). In sum, institutional committal results in the State being appointed as the legal guardian of State patients.

#### **2.2.8 Judicial management of State patients**

The Mental Health Care Act (2002) provides for the periodic review of the ‘incarceration’ of State patients in psychiatric hospitals (Burchell & Milton, 2005). Sections 46, 47 and 48 refer to mechanisms relating to discharge or conditional discharge from institutions. They cite a number of different people who can apply for discharge of a State patient:

The State patient himself or herself; an official *curator ad litem*; and administrator, if appointed; the head of the health establishment; the medical practitioner responsible for treatment; a spouse, an associate or next of kin of the state patient; or any other person authorized to act on his or her behalf (p. 399).

In the instance of State patients who have committed a violent offence (for example, murder and culpable homicide) the official *curator ad litem* referred to above is the Director of Public Prosecutions, who may challenge the application if they feel there is significant risk of public safety being threatened (Burchell & Milton, 2005). For other state patients applications are made via the hospital board who decides what type of discharge to grant, if any. Applications are then made to a Judge in chambers who makes the final decision whether the patient remains “a State patient; be reclassified and dealt with as a voluntary, assisted or involuntary mental health care user” or is discharged (Burchell & Milton, 2005, p. 400).

The role of psychology in the judicial process is explored in the following section.

## **2.3 PSYCHOLOGY AND LAW**

### **2.3.1 Competing paradigms within the psycholegal milieu**

There are many role players in the forensic system making it “truly a multidisciplinary area” (Gibbens, 1968, cited in Prins, 1980p. 1). Moreover, “...any claim to specialization [in this area] must lie in being able to cross...social and administrative boundaries, as well as in the specialized studies of particular mental conditions...” (p. 1).

The legal, and psychiatric paradigms have very different approaches to explaining human behaviour (Reznek, 1997), resulting in “an uneasy alliance” (Melton, Petrila,

Poythress & Slobogin, 1987, p. 3). On the one hand is the legal argument of the reasonable person with the capacity for free will. Here emphasis is often on linear and deterministic explanations for behaviour. On the other hand, complex, often deterministic, neurobiological explanations are offered from the psychiatric camp (Reznek, 1997). Thus, the crux of the distinction between the two is that psychiatrists look at causes of, and lawyers, reasons for, behaviour (Reznek, 1997).

Indeed, this is further confounded by different approaches between psychiatrists and psychologists (Howitt, 2002). Psychiatrists are frequently accused by psychologists of promoting the medical model of illness which ignores psychosocial aspects of mental functioning and personality. Howitt (2002) asserts that psychiatrists are trained to give medical explanations for mental illness, whereas psychologists are concerned with the assessment and evaluation of how the illness impacts on the moral appreciation and competency of the accused. It is thus highly probable that there will be conflicting evidence if the two professions arrive at different conclusions (Howitt, 2002), as these competing conclusions of mental capacity derive from entirely different theoretical ideologies (Reznek, 1997).

As psychologists are now becoming more meaningful players in the judiciary they are required to have a deeper understanding of the complexities of their role as objective forensic specialists (Louw & Allan, 1998). This complex role is examined in section 2.3.2 below.



### **2.3.2 Psychology in the forensic arena**

Finkel (1988) states that psychologists are frequently viewed equally with awe and suspicion by the court and the community. When the “forensic expert [psychologist] enters the courtroom to offer testimony, he or she often speaks in a language and thinks in dynamics that are foreign to lawyers, judges, and jurors” (p. 50). Thus, not infrequently, this leaves the bearers of the court questioning the scientific validity of psychology (Finkel, 1988).

Moreover, not infrequently, the determination of insanity frequently becomes a battleground of experts in deciding whether the accused is either ‘mad’ or ‘bad’ (Reznek, 1997). Although ‘insanity’ is a specifically legal term, psychiatrists and psychologists provide evidence and meaning to it. To a large extent these terms are informed by the taxonomy of the DSM which has shown to be malleable over time due to changes in value systems, expert opinion and advances in research (Howitt, 2002; Resnek, 1997). However, although psychology and psychiatry are scientific disciplines, diagnoses and testimony are more often than not deeply contested terrains (Allan & Louw, 2001; Resnek, 1997). Howitt (2002) notes that regularly, around the world, “[d]ifferent diagnosticians may put the same patient in very different categories” (p. 289). As a result, it is not uncommon for the legal fraternity to question the professionalism of forensic psychiatrists and psychologists (Allan & Louw, 2001; Resnek, 1997).

### **2.3.3 Forensic psychology in South Africa**

Louw and Allan (1998) conducted research on psychologists practicing in the forensic arena in South Africa. They note that “forensic psychology as a field remains poorly defined in South Africa” in contrast to other western countries (p. 234). Indeed, there is to date no formal designation of ‘forensic psychologist’ by the governing body of psychologists (HPCSA). However, the use of psychologists in the criminal courts is on the increase, particularly in areas of non-pathological criminal responsibility and pre-sentencing. Louw and Allan (1998) note though, that the volume of psycholegal work that South African psychologists have produced is still relatively low. Their concern is that this contributes to a vicious circle whereby the niche of forensic psychology is not being developed into a fully fledged discipline because psychologists are not willing or able to make a living exclusively through it. They assert that low case volumes may deny possibilities of psychologists gaining adequate forensic experience. This is further complicated by psychologists reporting that their training does not prepare them for forensic work, expert testimony and the writing of psycholegal reports. Consequently, Louw and Allan found that:

... a noticeable number of local psychologists who do forensic work fail to appreciate that expert witnesses need to be astute professionals and specialists in the relevant field of psychology and au fait with the relevant legal rules and procedures as well as ethical rules (1998, p. 239).

Unfortunately, this has resulted in much criticism of ‘forensic’ psychologists by the South African legal fraternity (Allan & Louw, 2001; Louw & Allan, 1998). Thus, it is advised that ‘forensic’ psychologists need to “change the paradigms they use, the

methods they use to gather information and make decisions, and how they express themselves in reports” (Louw & Allan, 1998, p. 239). The end result is that ‘forensic’ psychologists are seen to fall short in their role as expert witnesses. However, it is also argued that psychologists are a highly under-utilized resource which could contribute greatly to the psycholegal realm (Louw & Allan, 1998).

Nevertheless, psychologists are now more frequently assessing the mental state of those accused where there is a question of incapacity due to mental illness or defect (Allan & Louw, 2001).

#### **2.3.4 The role of psychologists in assessing mental state in criminal courts**

Psychologists play an important role in assisting the court in establishing criminal capacity (Africa, 2005). Evaluations are required if there is a question about the accused’s current mental state, and thus, fitness to stand trial. With pathological and non-pathological pleas, criminal responsibility needs to be established for the time of the alleged offence, and how pathological and non-pathological factors contributed to impairment of functioning which specifically led to the commission of the act (Africa, 2005).

As stated in the section dealing with procedural aspects of establishing ‘insanity’ above, the Criminal Procedures Act (s79, 51 of 1977), was amended in 1998 to specifically allow for the appointment of a clinical psychologist, at the courts discretion (Kaliski, 2006). The Act specifies the referral of the accused for psychiatric or psychological

assessment should there be a question regarding his/her mental state. This is a significant move in South African legal history as previously, although psychologists were conducting assessments, this service was not provided for in the Act (Louw & Allan, 1998). Thus, clinical psychologists are now formally recognised as meaningful contributors to assisting the courts with criminal incapacity due to mental illness or defect.

It should be noted that it is not the psychologist or mental health worker who makes a decision about the accused's mental state (Africa, 2005), this is for the court to decide from the basis of the expert testimony, referring to the ultimate issue rule (Allan & Louw, 2001). Therefore, "the issue of determining criminal responsibility is a legal question while the evaluation of mental state is a psychological question" (Africa, 2005, p. 398).

### **2.3.5 Perceptions of psychologists as expert witnesses**

Allan and Louw (2001) conducted research in South Africa on lawyers' opinions of psychologists who act as expert witnesses. They note with concern that their findings show that lawyers significantly "did not believe that the potential value, or actual contribution, of psychological testimony was high" (p. 12). This was linked to skepticism regarding psychologists as biased, psychologists as making too many concessions under cross-examination, and psychologists largely failing in lawyers' expectations of their knowledge as experts in the field of psychology (Allan & Louw, 2001).

However, despite criticism of psychologists as expert witnesses, South African judges have in the past expressed the need for psychological testimony in assisting the court (Allan & Louw, 2001). Moreover, Allan and Louw (2001) state that psychologists are an under- utilized resource in South Africa in comparison to the United Kingdom, United States, Australia and New Zealand.

## **2.4 THE INSANITY DEFENCE AS AN ARTIFACT OF VIOLENT CRIME**

As has been mentioned above, in order for an insanity defence raised, a concomitant crime is required (Kaliski, 2006).

There have been controversial and contradictory findings in the interface between mental disorders and violent crime in relation to risk assessment and predictions of dangerousness (Cohen, 2005). Early research suggested that although there were no significant differences for non-violent crimes, psychiatric patients were found to commit more violent crimes than their 'normal' cohorts (Cohen, 2005). This was contested by later research results which, when controlling for other social variables, found no distinction between mentally ill offenders and normal cohorts. However, recent evidence has more conclusively linked specific mental illnesses, such as schizophrenia with violence (Cohen, 2005). The extensive history of research in this field has largely been prompted by the trend of de-institutionalising psychiatric patients. However, although research continues, an incidental finding to the research underpinning this debate is that mental health professionals find the reliable predicting of violence in psychiatric patients very difficult (Cohen, 2005).

Following the assassination of Verwoerd, efforts were made by the South African state to monitor possible violent psychiatric out-patients (Cohen, 2005). This led to the introduction, and later repealing of psychopathy as a mental illness (Cohen, 2005). More recently, legislation has introduced indefinite sentences for offenders who were considered violent (but not necessarily mentally ill). However, lately some debates in the appeal court have begun to test indefinite sentences (Cohen, 2005).

Cohen (2005) notes that “[t]he notion of ‘risk of harm to others’ is threaded through South Africa’s Mental Health Care Act (2002)”. Mental health care professionals are thus by inference required to make an estimation of risk to the community at large (p. 268). It is important to remember that the Act functions for the safety of the patient as well as the community (Cohen, 2005).

Contextually, for South Africans, violent crime is cause for significant public unease. Indeed, Dissel (2002, cited in Cohen, 2005) notes that South Africa has one of the highest rates of violent crime in the world, and furthermore, that recidivism is between 85 and 94%. Moreover, Cohen (2005) asserts that because the rate of rape and murder is so high, risk assessments of dangerousness are concomitantly high on the political agenda, putting pressure on mental health professionals to be more conservative in their appraisals.

#### **2.4.1 ‘Mad’ versus bad**

Judiciaries have for centuries had to grapple with the distinction between mad and bad in deliberating an insanity defence (Reznek, 1997; Skeem & Golding, 2001). This

conundrum is increasingly being played out regarding extreme sociopathy whereby defendants are charged with heinous crimes incomprehensible to laypeople (Rezneck, 1997). Skeem and Golding (2001), note that the controversy has both historically and currently been centred on whether defendants should be absolved of criminal responsibility because they are 'morally insane'. However, Rezneck (1997) argues that as a moral society it is important to maintain the insanity defence in protecting those that are genuinely mentally ill or cognitively incapacitated at the relevant time. Therefore, in his view, it is important to legally distinguish between those that are 'evil' and those that are 'ill'.

In the 19<sup>th</sup> century psychopathy was described as “a selectively diseased state of will in an otherwise intact individual”, an “irresistible impulse’ to commit an offence... manifested by a single, unpredictable, heinous act committed with no apparent motive” (Ray 1861 cited by Belkin, 1996; Fullwinder, 1975, in Skeem & Golding, 2001, p. 593). Although there was much debate then about whether to allow moral insanity as a legal defence, it was finally rejected following a high profile case in 1881 (Skeem & Golding, 2001). In the 20<sup>th</sup> century the terminology shifted from moral insanity to moral depravity to psychopathy or antisocial personality disorder (Skeem & Golding, 2001), as reflected in current psychiatric nosology, the DSM-IV-TR (American Psychiatric Association, 2000).

However, in South Africa, psychopathy was previously regarded under the Mental Health Care Act as a certifiable mental illness (Louw, 2006). The Criminal Procedures Act was

amended in 1993 thereby removing psychopathy as a mental illness (Louw, 2006). With regard to ‘psychopaths’ or dangerous offenders, the South African legal system has shifted from accommodating such offenders in rehabilitative psychiatric hospitals to labeling them as dangerous criminals and incarcerating them in prison for indefinite periods of time under Sections 286A and B of the Criminal Procedures Act (Burchell & Milton, 2005). Thus, personality disorders do not currently satisfy the requirements for the legal definition of insanity.

The reasoning behind this is that personality disorders are “not a consequence of disturbance of the psychic state but rather patterns of behaviour learned during the formative years” (Burchell & Milton, 2005, p. 386). The legal precedent laid down by Justice W H Booysen states that viewing psychopathy as an illness “is not only scientifically untenable, but is also not effective in practice (cited in Burchell & Milton, 2005, p. 387). This hinges on the issue of criminal capacity whereby psychopaths are regarded as *doli capax* because “he knows what is and what is not lawful and he has the mental capacity to act accordingly” (Rumpff CJ 1976 cited in Burchell & Milton, 2005, p. 388). However, Burchell and Milton (2005) cite cases where personality disorder impairments may underpin extenuating circumstances or may be argued in mitigation of sentence.

Interestingly, Skeem and Golding (2001) found that one third of their sample believed that psychopathy contained elements of insanity. This demonstrates that common lore continues to confuse psychosis with psychopathy, thereby conceptualising the insane



offender as “a malevolent, detached, irrational, and unpredictably violent offender” (Skeem & Golding, 2001, p. 592). This perception endures even though the conflation is both contradictory and illogical (Skeem & Golding, 2001). Carson, Butcher and Mineka (1998, cited in Skeem & Golding, 2001, p.594) state that these perceptions have deep historical roots from when madness was associated with “demonic possession or with the punishment for sin”. This is underscored by Skeem and Golding’s (2001) sample who appropriately complained that they found it very difficult to draw a distinction between psychopathy and insanity.

#### **2.4.2 Szasz’s argument against the insanity defence**

Szasz (1990; 1994) argues for the abolition of the insanity defence as he believes there is no such thing as mental illness, thereby nullifying the mad/bad distinction (Rezneck, 1997).

Szasz (1990; 1994), one of the major proponents of ‘anti-psychiatry’, argues that all human beings are moral agents and thus should be held accountable for their actions. Concomitant to his argument is that the ‘mentally ill’ cannot be deprived of their liberty if they are innocent, and should be punished if guilty. Thus, he contends that “(mis)behaviours are not diseases” but are named thus for the purposes of coercion by psychiatrists and the State to both medicate and institutionalise (1994, p. 34). For anti-psychiatrists, coercion refers to labeling deviancy as a justifiable means and form of social control by the state (Cohen, 2005). Moreover, in the state controlling ‘deviancy’ by identifying with the medical model and thereby medicating and

institutionalizing people because of mental illness, pathogenic aspects of our society are obfuscated (Cohen, 2005).

Szasz states that it is misleading to assume that insanity stems from a biologically medical cause (cited in Rezneck, 1997; Szasz, 1994). He argues that 'insanity' is not an illness but has become a convenient excuse for badness because it is described within the medical discourse. This is particularly the case when inexplicably violent crimes are committed which society attributes to madness, thus confusing badness with insanity (Rezneck, 1997).

## **2.5 PUBLIC PERCEPTIONS OF THE INSANITY DEFENCE<sup>2</sup>**

### **2.5.1 Research on jurors' attitudes to the insanity defence**

Skeem (Skeem & Golding, 2001) has done extensive research over a number of years in the United States on jurors, mock jurors and university students, and their perceptions of the insanity defence. Her research consisted of a series of studies comprising qualitative and quantitative methodology.

Skeem and Golding's (2001) research is particularly important as it assesses belief systems about insanity, and explores the interface between law and psychology. They make the significant point that jurors are not the blank slates the law purports them to be,

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<sup>2</sup> Skeem and Goldings (2001) research on opinions of the insanity defence was cited here because Skeem was the author of the Likert scale used in this research. Although other bodies of research are referred to by Skeem and Golding, and listed in online databases, the cost of purchasing them were prohibitively expensive.

as they have life experiences and stereotypical opinions that frame their understandings of both what the courts requires of them and of what it means to be incapacitated through mental illness. Therefore, their “preconceptions and attitudes affect their legal decision making” skills (p. 561).

Of concern, although jurors are instructed to be impartial, it has been found that their attitudes are biased against the insanity defence and this may be detrimental in their deliberations of verdicts. Negative biases were described as “grossly inaccurate as well as inflexible” (Skeem & Golding, 2001, p. 563). The inaccuracies cited here refer to opinions that the insanity defence is a loophole in the law which is not only frequently raised, but allows ‘sane’ criminals to be absolved of responsibility and given opportunities to re-offend and thus threaten public safety (Skeem & Golding, 2001). They cite research which consistently demonstrates that negative biases are not only prevalent, but enduring even when respondents are shown conclusive statistical evidence to the contrary. Moreover, research is demonstrating that jurors, not uncommonly, don’t fully understand instructions given to them on legal definitions of insanity and “interpret instructions differently in light of their own experiences” thus demonstrating intuitive as opposed to accurate understandings of insanity (Skeem & Golding, 2001, p. 564).

Much research shows that the lay public has very poor conceptualisations of mental illness (cited in Skeem & Golding, 2001). Roberts and Golding (1991, cited in Skeem & Golding, 2001) found that there was a strong correlation between jurors’ attitudes towards the insanity defence, the way in which they interpreted the case, and the final

verdict. However, Finkel and Handel (1989, cited in Skeem & Golding, 2001) found that “no single construct is determinative across cases or describes the essence of insanity” (p. 567). All research results considered, Skeem and Golding (2001) state that the lay public’s negative opinions of the insanity defence raises the possibility of defendants not receiving a fair trial under a jury system.

Although the lay publics’ understanding of insanity does not correspond well with legal definitions, there is very little overlap between their opinions and those of psycho-legal experts (Skeem & Golding, 2001). In fact, “[m]ost laypeople are unfamiliar with expert definitions of these constructs and define them differently than experts do” (Skeem & Golding, 2001, p. 575).

Indeed, the wild beast test of 1724 has held sway for centuries largely because it is an embedded ideological construct within western societies (Skeem & Golding, 2001). Of interest, research is demonstrating that this perception still holds currency to this day (Perlin, 1994 cited in Skeem & Golding, 2001). They ascribe this to formidable media representations of the “mentally ill as fundamentally inhuman and sometimes as “slow, backward and inarticulate”” (Wahl, 1995 cited in Skeem & Golding, 2001, p. 592). It was only in the 19<sup>th</sup> century that saw reform for the insane in the form of liberalizing the way in which the ‘insane’ were treated, effectively raising their status from that of a beast to a human being (Skeem & Golding, 2001).

Skeem and Golding (2001) employed prototype theory to explain jurors' intuitive understandings of the insanity defence. Prototype theory refers to the ways in which individuals broadly categorise experiences or opinions stereotypically to form prototypes which are then generalised to explain constructs which have similar attributes (Skeem & Golding, 2001). In essence, prototypes are "preconceptions and attitudes" which are informed by past experience and become belief systems, which are then extrapolated to interpret new experiences. Thus, prototypes drive worldviews which by their nature are stereotypical as individuals use their past experiences/beliefs as a template for their opinions. Consequently, opinions are frequently incorrect, particularly where emotive issues, such as the insanity defence, are raised. Therefore, it is important to note that prototypes will vary according to learning experiences, and across cultures and thus, can be highly heterogenous and multifaceted (Skeem & Golding, 2001). They cite numerous research studies which support their hypotheses that "[j]urors have prototypes of the criminally insane that organise the piecemeal information that they informally encounter about insanity and that these prototypes guide their legal decision making" (p. 569).

Moreover, the lay public has a prototype for the 'criminal madman' (Cantor et al., 1982, cited in Skeem & Golding, 2001). This prototype is exemplified mostly by psychiatric symptoms, mental state at the time of the offence, personality characteristics, and interaction with the mental health system (Skeem & Golding, 2001). This indicates that prototypes can concur with the criminal justice system's requirements, though Skeem and Golding's findings were that "jurors do not substantially agree on even a subset of the features that characterize insanity" (2001, p. 582). However, they found three broad

prototypes: severe mental disability (chronic functional or intellectual impairment), moral insanity (psychopathy) and mental state-centred characteristics (impairment in mental status). An overlapping and underlying feature of the three prototypes was psychosis, particularly cognitive and volitional impairments due to psychotic disorder. Skeem and Golding (2001) note that although these prototypes concur with legal requirements for the insanity defence, they converge with more simplistic and extreme notions such as the wild beast test of 1724 (consistent with prior research conducted by Hans & Slater, Perlin, 1997; 1984; Roberts et al., 1987 cited in Skeem & Golding, 2001). This implies that “jurors are more inclined to deem defendants with physical impairments such as mental retardation insane, than those with ‘strictly psychiatric’ impairments” (Skeem & Golding, 2001, p. 591).

An important feature of the distinctive prototypes distilled from Skeem and Goldings’ (2001) research is that jurors expect impairments to be supported by expert evidence and be independent of substance use. Thus, expert evidence and testimony are critical salient features for jurors’ deliberations on the insanity defence (Finkel & Groscup, 1997; Ogloff, 1991 cited in Skeem & Golding, 2001).

A significant finding by Skeem and Golding (2001) is that a third of their sample believed it wrong to punish defendants who are mentally ill. Less than one quarter of the sample believed that the insanity defence was justified and “that the constitutional rights ascribed to defendants were necessary components of the legal process” (p. 605). Of interest, in parallel research findings (Skeem, 1999 cited in Skeem & Golding, 2001),

those that upheld the insanity defence were much less authoritarian in their attitudes than those who didn't. However, they found a discrepancy between male and female views, with educated men more supportive of the insanity defence than women. They cite research which "found that gender-related differences in prototypes were attributable to differences in life experiences" (Kempton, 1981 cited in Skeem & Golding, 2001, p. 601). More specifically, that women may feel more vulnerable than men because of media depictions of themselves as targeted by 'madmen' (Wahl, 1995 cited). And further research which demonstrated that "women perceive the mentally ill as more dangerous than men" (Ryan, 1998 cited, p. 601).

Consequently, of grave concern, their aggregate findings suggest that jurors' views did not correspond well with the law, did not believe in the merits of the insanity defence and as a result were much more inclined to convict (Skeem & Golding, 2001).

## **2.6 SUMMARY**

The insanity defence under South African law is referred to more appropriately as pathological and non-pathological incapacity, and allows for defendants to be found not guilty by reason of insanity. The disposition of defendants varies depending on the plea, with pathological incapacity resulting in indefinite committal as State patients in psychiatric institutions, and non-pathological incapacity with acquittal.

Having reviewed the literature on the judicial process, the role of psychologists in establishing criminal incapacity and previous research on lay public's opinions of the

insanity defence, the methodology and results of this research study will be presented in chapters 3 and 4 below.



## **CHAPTER THREE**

### **METHODOLOGY**

#### **3.1 AIMS AND RATIONALE**

The impetus behind this research is based on American research which surveyed lay assumptions about the insanity defence (Skeem & Golding, 2001). This prompted eliciting opinions of South African clinical psychologists toward the insanity defence, and became the aim of this research study. Specifically, it was considered important to canvas clinical psychologists' opinions of the insanity defence since the Criminal Procedures Act (s79, Act 51 of 1977, amended in 1998) has enabled clinical psychologists to increasingly become meaningful contributors to the South African forensic setting (Kaliski, 2006). Moreover, the escalating rate of violent crime in South Africa (Dissel, 2002 cited in Cohen, 2005) raises the importance of deliberating the merits of such a defence.

#### **3.2 RESEARCH QUESTIONS**

Research questions were employed, as opposed to hypotheses, as no previous research literature was found on psychologists' opinions of the insanity defence. Thus, this is essentially an explorative study (Punch, 2004).

Question 1: Will the *Insanity Defense Attitude-Revised* (IDA-R) scale scores demonstrate broad differences of opinion about the insanity defence amongst the clinical psychologists sampled?

- Question 2: Will there be an association between IDA-R scale scores and the sample's gender, race or age?
- Question 3: Will there be an association between IDA-R scale scores and clinical psychologists' therapeutic orientation or primary work setting?
- Question 4: Will there be a significant association between IDA-R scores and clinical psychologists who have more practice experience, forensic experience and who have processed more criminal cases?

### **3.3 RESEARCH DESIGN**

This is an exploratory nomothetic, cross sectional quantitative study, as no other South African research has been done with clinical psychologists on this topic. Thus, this research aims to collect some descriptive data on the main research question, and to explore some inter-relationships between variables using a correlational design. The correlational design has been selected because it "...measures two or more characteristics of the same individuals [and] computes the correlation of these characteristics" (Woodworth cited in Goodwin, 2002, p. 148). All the variables are treated alike as they are essentially subject variables, with there being no true independent variable (Woodworth cited in Goodwin, 2002). In accordance with the theory behind correlational research, no inferences will be made about the causal relationships between the variables

(Goodwin, 2002; Rosnow & Rosenthal, 1996). However, the strength of the association between two variables will be examined using Pearson  $r$  as the correlation coefficient of choice (Rosnow & Rosenthal, 1996).

### **3.4 INSTRUMENTS**

#### **3.4.1 Demographic data sheet**

An anonymous questionnaire requesting information on each respondent's personal and biographical details, experience and qualifications (Appendix A) was attached to the attitude scale detailed below.

#### **3.4.2 Insanity Defense Attitude-Revised scale (IDA-R)**

Skeem and Evans-DeCicco (2004) developed this scale (Appendix B) to assess potential jurors' attitudes towards defendants who used the insanity defence in the United States. More specifically, its aim was to provide a useful tool to attorneys during the jury selection process. This scale arose out of Skeem's extensive research into opinions about the insanity defence (Skeem & Golding, 2001).

Although it is purported to be "a psychometrically sound assessment" (Skeem & Evans-DeCicco, 2004, p. 187) no data on reliability and validity of the scale could be found in the original publication, and several attempts to obtain this information were unsuccessful. However, Skeem, the principal author of the scale, attests that the "IDA-R

has adequate convergent and discriminant validity and predicts insanity case judgements relatively strongly” (cited in Skeem & Golding, 2001, p. 584).

The scale assesses two factors:

1.      **Strict Liability-Reduced Capacity.** This refers to the opinion that “mental illness is relevant to the issue of criminal responsibility” and therefore a mitigating factor in deliberating the accused’s criminal capacity (Skeem & Golding, 2001, p. 584).
2.      **Perceived Injustice and Danger.** This refers to the extent to which opinions about the insanity defence are negatively biased, whereby the lay public believes it is used to evade responsibility and return dangerous offenders to the streets, only to re-offend (Skeem & Golding, 2001).

The scale is provided with its own scoring system (Appendix D) which has a range of scores from 17 to 119. The lower the score the more a respondent is in favour of the insanity defence, with high scores denoting not only lack of support of this defence, but also lack of faith in the criminal justice system (Skeem & Evans-DeCicco, 2004). If one takes the midway point between the IDA-R scale score’s lower (17) and upper (119) limits, the average score obtainable is 68. In order to establish cut-off points for interpretation of the scores, this study assumes that on a continuum, scores above 69 denote low support for the insanity defence, graduating toward extremely negative opinions. Scores between 17 and 37 denote strong support for the defence, scores

between 38 and 47 demonstrate moderate support, and scores between 48 and the midpoint of 68 suggest some ambivalence about the defence.

### **3.5 PROCEDURE**

This sample was selected from the HPCSA's 2002 list of registered clinical psychologists to which the researcher had access. The total number of clinical psychologists ( $N = 1837$ ) was alphabetized and allocated a number from 1 to 1837 on an Excel spreadsheet. The targeted number of recipients for this study was 500 which was approximately one quarter of the practicing clinical psychologists in South Africa. In order to obtain a systematic sample (Katzenellenbogen, Joubert & Abdool Karim, 1999) the total of 1837 was divided by 500 which indicated that approximately every fourth psychologist should be selected. Of these, 20 were living outside of South Africa and were thus excised. Any clinical psychologists who had been canvassed by another Masters student in 2006 were removed so as to not tax the same psychologist twice and thus attempt to improve the response rate. This process of ratio selection was done five times with each round being colour coded to ensure a systematically representative sample, until 500 clinical psychologists were selected within South Africa.

This is considered a purposive sample as clinical psychologists were specifically selected for two reasons. Firstly, in their training they would have experience assessing and understanding mental illness and retardation; and secondly, it is clinical psychologists, as opposed to other registered categories, who are generally requested to assist the court on

matters of 'insanity'. Thus, it is seemed important to canvas their opinions of the insanity defence as they are becoming increasingly meaningful players in our judicial system.

On the 15 May 2006 the questionnaires together with the demographic data sheet and a brief letter from the author (Appendix C) was posted to the 500 clinical psychologists with self-addressed reply paid envelopes for them to return the completed questionnaires. The envelopes and letters had the UKZN Pietermaritzburg Psychology Department's letterhead to give the research added credibility (Yammarino, Skinner & Childer, 1991). The author's cellular and after hours telephone numbers, and email address were included should any of the respondents have any queries. Due to time and resource constraints no follow up was made to facilitate the response rate.

### **3.6 QUALITY OF RESPONSE**

Although the initial deadline for the return of questionnaires stated in the covering letter was set for 15 July 2006, this was extended to 31 August 2006, by which time 12.8% ( $n = 64$ ) replied with useable and completed data sheets and questionnaires. Four respondents (0.08%) marked their questionnaires 'incomplete' to indicate that they were unable to participate in the survey. An unanticipated source of data for this research was, of the 64 useable questionnaires, 14 (22%) of the respondents had annotated comments to the questionnaires expressing opinions of the insanity defence. Of the 500 questionnaires mailed, 8% ( $n = 41$ ) were returned to sender due to the addresses being incorrect.

The data derived from the demographic data sheet and IDA-R scale scores was entered into the SPSS 13 (2006) programme for statistical analysis.

### **3.7 SAMPLE**

The sample for this research study consisted of 64 clinical psychologists who responded to the mailed questionnaire. This sample has representation from the four South African race groups, namely, Black, Indian, White and Coloured. Their university and date of completion of training, as well as their highest qualification was canvassed. This was combined with information gleaned on their primary work settings and therapeutic orientations; their years in psychological practice and forensic experience; and the number of criminal cases they may have processed.

### **3.8 ANALYSIS OF DATA**

Since no clinical psychologists have previously been researched regarding their opinions of the insanity defence, this research is largely exploratory, employing descriptive statistics to extrapolate the characteristics of this sample in terms of their demographic data and representation of the IDA-R Scale scores (Coolican, 1999). Some inferential statistics were deployed to further this aim.

Although Skeem and Golding's (2001) research informed this study, their methodology and means of data analysis were not replicated for two reasons. Firstly, the IDA-R scale formed a very small portion of Skeem's overall research which spanned 3 interconnected studies consisting of qualitative and quantitative components. Secondly, very little detail

was given regarding their methods of analysis for the IDA-R segment of their research. What could be ascertained is that a correlational matrix and factor analysis was employed, together with a MANOVA in comparing the IDA-R scores with two other scales used. Although two factors were published, no detail was given about how the 32 point scale was reduced to the 2 stated factors. Reliability coefficients were not declared in the original publication. It was felt that without documentation of how factors were allocated in Skeem's (2001) research, no comparison could be made with this study. For reasons explored below, it was felt that non-parametric tests were more appropriate than parametric tests.

Due to some aspects of this sample's variance, containing extreme scores, it was decided to employ non-parametric tests because they are considered distribution-free tests (Howell, 2002). Moreover, due to the small sample size, non-parametric tests were considered more suitable than parametric tests (Goodwin, 2002). Additionally, non-parametric tests are sensitive to median values and are relatively unaffected by extreme scores because of their ranking procedures (Howell, 2002). Therefore, it is argued that the liberal assumptions of the non-parametric tests allow for this exploratory research process (Howell, 2002).

All statistical procedures detailed below employed the use of each participant's aggregate IDA-R scale scores as a quantifiable measurement of their attitude toward the insanity defence. All percentages referred to in the text, unless stated to the contrary, used the sample size of 64 as the denominator.



A reliability coefficient (Cronbach's alpha) was calculated to determine the reliability of the IDA-R scale to determine the internal consistency of the questionnaire (Durrheim, 1999c).

The Mann-Whitney U test was used to extrapolate possible differences in opinion measured by the IDA-R scale scores in terms gender. This non-parametric test is known as the analogue to the *t* test for independent groups, and is considered appropriate in measuring a small sample with heterogenous variances (Coolican, 1999; Heiman, 2001). The observed *z* is reported because one or more of the groups is larger than 20 (Morgan, Reichert & Harrison, 2002).

Correlation coefficients were calculated amongst all the variables to identify possible inter-relationships which had not been anticipated by the research questions. Pearson's *r* was selected as the coefficient of choice in extrapolating the degree of relatedness between variables (Rosnow & Rosenthal, 1996). Categorical variables were dummy coded to facilitate measurement with continuous variables (Rosnow & Rosenthal, 1999). Correlation coefficients were thus able to be used to detect possible statistically significant relationships between IDA-R scores and the participants' therapeutic and practice orientations, and their experience as measured by practice years, forensic years and criminal cases processed.

Finally, race by IDA-R scale scores were tabulated using the Chi-Square test for nominal data (Coolican, 1999). Race was difficult to compute because of high variances,

combined with some race groups having only two representatives in the sample (Heiman, 2001). Although the assumptions of the Chi-Square test were violated due to there being less than the five expected respondents for some race categories, it is believed that the flexible assumptions of non-parametric tests allow for these results to be presented in this research (Howell, 2002).

The descriptive and inferential results extrapolated from the data analysis will be presented in the next section.

## CHAPTER FOUR

### RESULTS

#### 4.1 DESCRIPTIVE CHARACTERISTICS OF SAMPLE

This section explores the demographic data (race, age, gender) of the clinical psychologists sampled ( $N = 64$ ). A disclaimer was included next to the request to specify the race group of respondents stating that “[u]nder apartheid reference to race was generally seen as offensive. For this study race is a variable of academic interest only” (see Appendix A). Further information was requested on the data sheet such as the respondents’ highest qualification, university of training, professional experience, therapeutic orientation and primary work setting. Although some ( $n = 4$ ) of the questionnaires were missing some demographic data they were included in the statistical analysis.

Table 1

*Cross-tabulation of race by gender.*

		White	Black	Coloured	Indian	Total
Gender	Male	22	3	0	2	27
	Female	25	4	2	0	31
Total		47	7	2	2	58

$N = 58$

Table 1 show that male and female psychologists were almost equally represented, with female respondents representing 48.4%, and male respondents representing 42.1% of the sample respectively. In terms of the race variable, White respondents comprised 73.4%

( $n = 47$ ), with Black respondents reflecting 10.9% ( $n = 7$ ), and Indian and Coloured both at 3.1% ( $n = 2$ ). Although this is not an accurate reflection of the racial representation of South Africa's population (Statistics South Africa, 2006), it is considered a rough approximation of the racial profile of psychologists currently registered with the HPCSA (Duncan, Van Niekerk & Townsend, 2004).

Table 1 further breaks down the data by the race of respondents. The results show that White women (39%) dominated the sample, with their male (34%) counterparts a close second. Four percent of the respondents were Black men, with Black women representing 6% of the sample. Coloured and Indian respondents were represented solely by women (3%) and men (3%) respectively. It should be noted that these numbers were confounded by missing data for both variables.

Table 2

*Means and standard deviations of race by age.*

Race Group	Mean Age	<i>n</i>	Standard Deviations
White	48.4	49	12.43
Black	45.6	7	7.89
Indian	52.5	2	0.707
Missing		6	
Total	48.2	64	11.75

$N = 64$

The samples' age representation (Table 2) had a mean of 48.2 years with the median and mode coinciding at 46 years ( $SD = 11.09$ ). A broad range of ages was evidenced (range = 51 years). When considering this variable by race, however, overall, age tended to

cluster around the late forties. Coloured respondents could not be tabulated as neither of the participants included their age.

Figure 1

*Age in years by experience: Forensic and practice years, and criminal cases processed.*

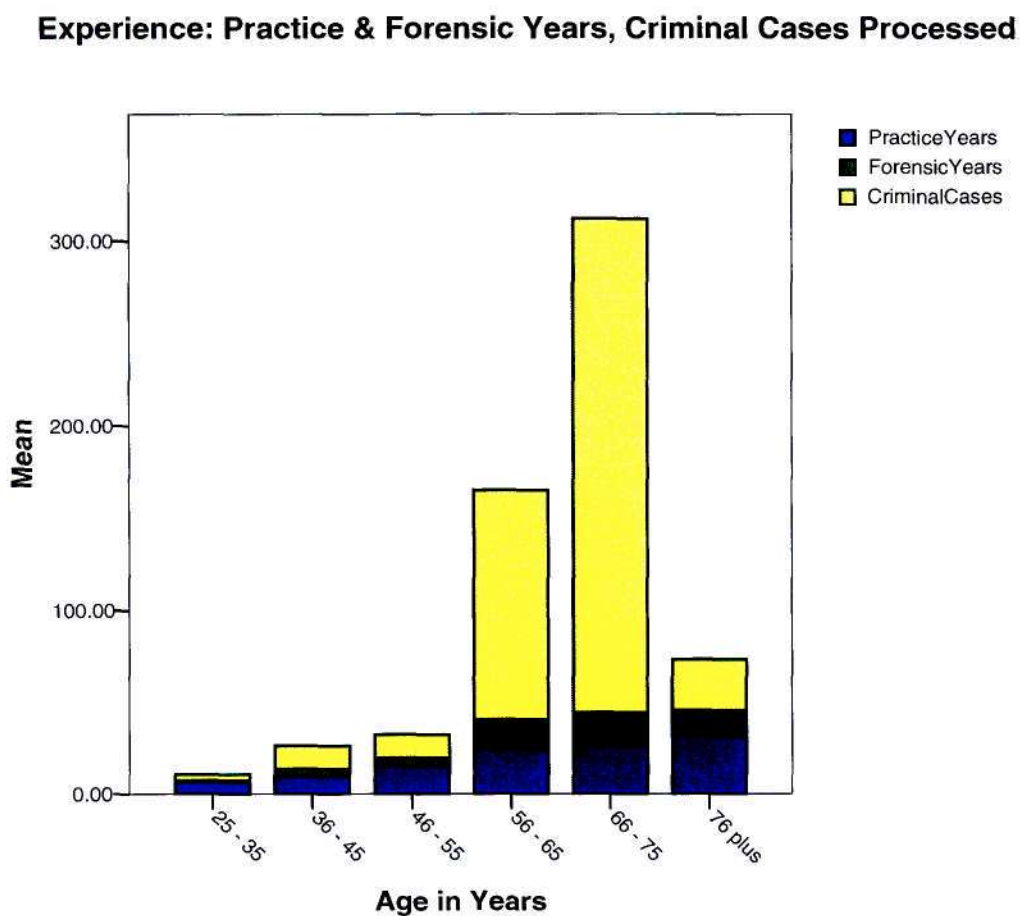


Figure 1 depicts age by experience in terms of years in practice, forensic years and criminal cases processed. This figure dramatically demonstrates that the bulk of this samples' experience, particularly forensic experience, lies with psychologists who are

aged 56 and older. Not unexpectedly, relatively strong correlations found that older psychologists dominated the field in terms of experience as measured by practice years ( $r = 0.727, p < 0.05$ ) and forensic years ( $r = 0.541, p < 0.05$ ), and criminal cases processed ( $r = 0.294, p < 0.05$ ).

Table 3

*Frequencies of practice and forensic experience for clinical psychologists.*

Years	Practice Experience		Forensic Experience	
	<i>n</i>	%	<i>n</i>	%
0	0	0	29	45.3
1 – 5	8	12.5	10	15.6
6 – 10	18	28.1	6	9.38
11 - 15	7	10.9	6	9.38
16 - 20	12	18.8	7	10.9
21 - 25	8	12.5	1	1.56
26 plus	9	14.1	2	3.13
Total	62	96.9	61	95.3
Missing	2	3.13	3	4.63
Total	64	100	64	100

*N* = 64

In terms of professional experience the sample demonstrated broad ranges (Table 3). The sample's years in practice had a mean of 15.17 years. However, the range was 44 years with bimodal years between 6 and 8 years ( $SD = 9.28$  years). For forensic experience, the sample had a mean of 6.42 years. However, the modal value was 0 years with a range of 36 years ( $SD = 8.88$  years). Table 3 shows that almost half of the sample had no forensic experience (45.3%,  $n = 29$ )

Table 4

*Frequencies of psychologists who have processed criminal cases.*

	No. of Criminal Cases	Frequency	Percent	Valid Percent	Cumulative Percent
Valid	0	25	39.1	40.3	40.3
	1	8	12.5	12.9	53.2
	2	4	6.25	6.45	59.7
	4	1	1.56	1.61	61.3
	5	3	4.69	1.61	66.1
	6	1	1.56	1.61	67.7
	8	1	1.56	1.61	69.4
	10	1	1.56	1.61	71
	17	1	1.56	1.61	72.6
	17.5	1	1.56	1.61	74.2
	20	4	6.25	6.45	80.6
	25	1	1.56	1.61	82.3
	28	1	1.56	1.61	83.9
	30	5	7.81	8.06	91.9
	100	1	1.56	1.61	93.5
	120	1	1.56	1.61	95.2
	150	1	1.56	1.61	96.8
	600	1	1.56	1.61	98.4
	1000	1	1.56	1.61	100
Missing	Total	62	96.9	100	
	System	2	3.13		
Total		64	100		

*N* = 64

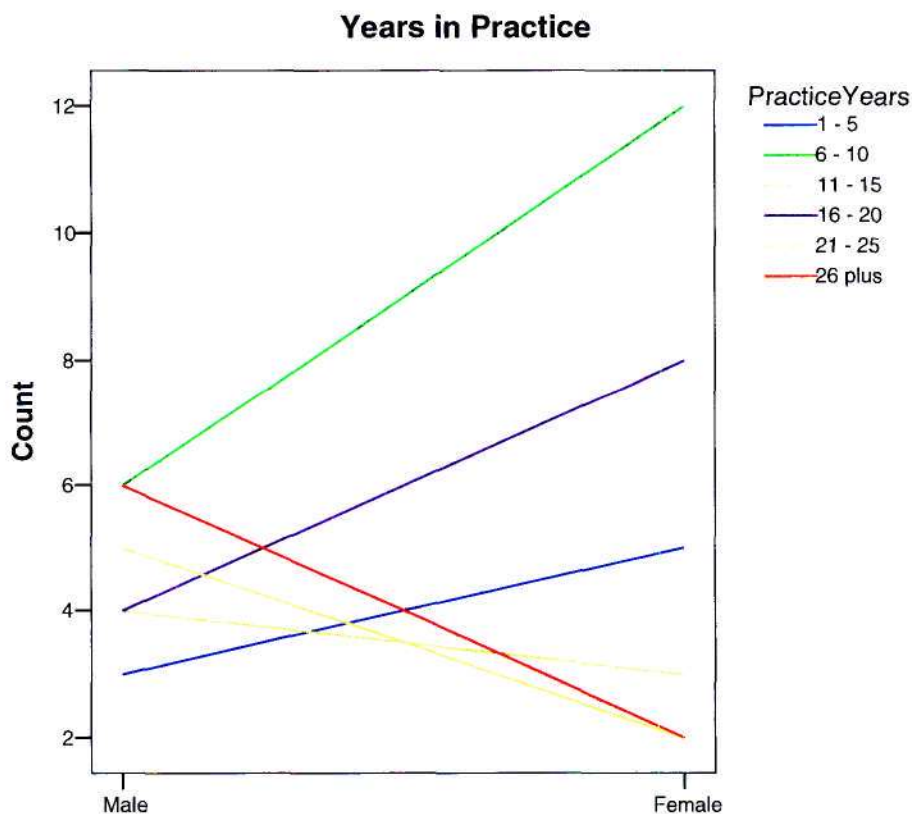
The number of criminal cases processed (Table 4) produced the largest variance amongst the sample, with a broad standard deviation of 147.46 cases and a range of 1000 cases. Here the measures of central tendency differed substantially, with the mean, mode and median at 37.84, 0, and 1 cases respectively. Thirty-nine percent ( $n = 25$ ) of the sample had not professionally been exposed to criminal/forensic cases, with a very small proportion (7%,  $n = 5$ ) having processed more than 100 cases. Of interest, in terms of

gender, although more women ( $n = 16$ ) than men ( $n = 9$ ) had not processed any criminal cases, the respondent with the most reported criminal case experience was a woman ( $n = 1000$ ).

Those practitioners who had more years of practice experience had statistically significantly more years of forensic experience ( $r = 0.667, p < 0.01$ ), and number of criminal cases processed ( $r = 0.349, p < 0.01$ ). Moreover, not unexpectedly, those with forensic experience had processed the most criminal cases ( $r = 0.414, p < 0.01$ ).

Figure 2

*Gender by years in practice.*

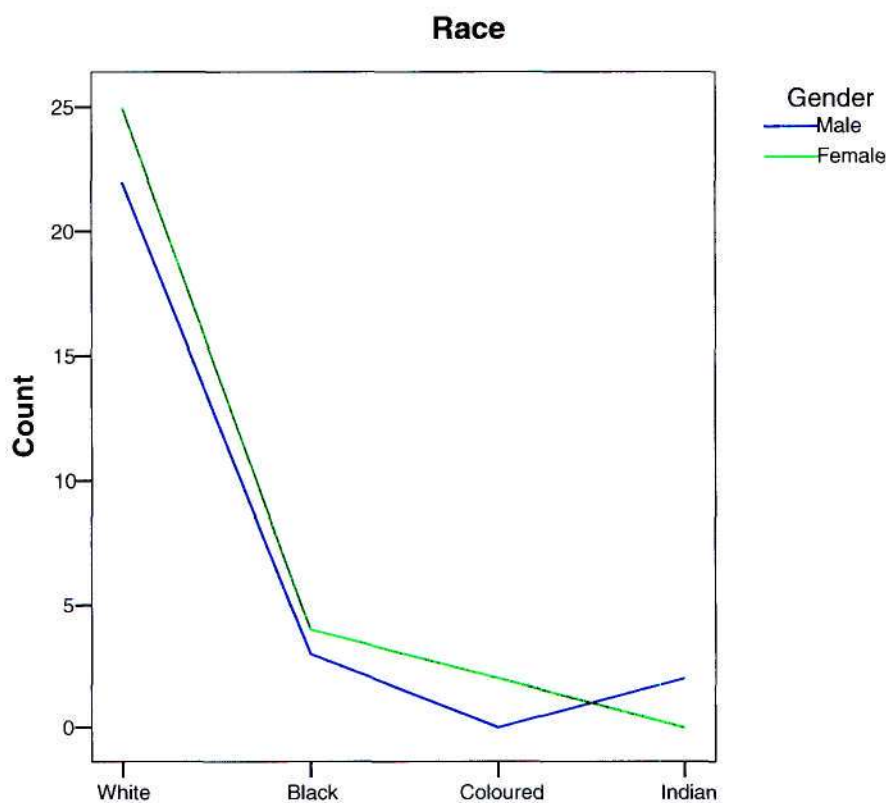




Analysis of gender by years in practice (Figure 2) demonstrates a pattern where female psychologists have in the past 15 years begun to dominate the field in terms of their overall numbers, thereby corresponding well to Richter and Griesel's (1999) findings demonstrating the feminization of psychology post 1999 (cited in Pillay & Kramers, 2003).

Figure 3

*Race by gender.*

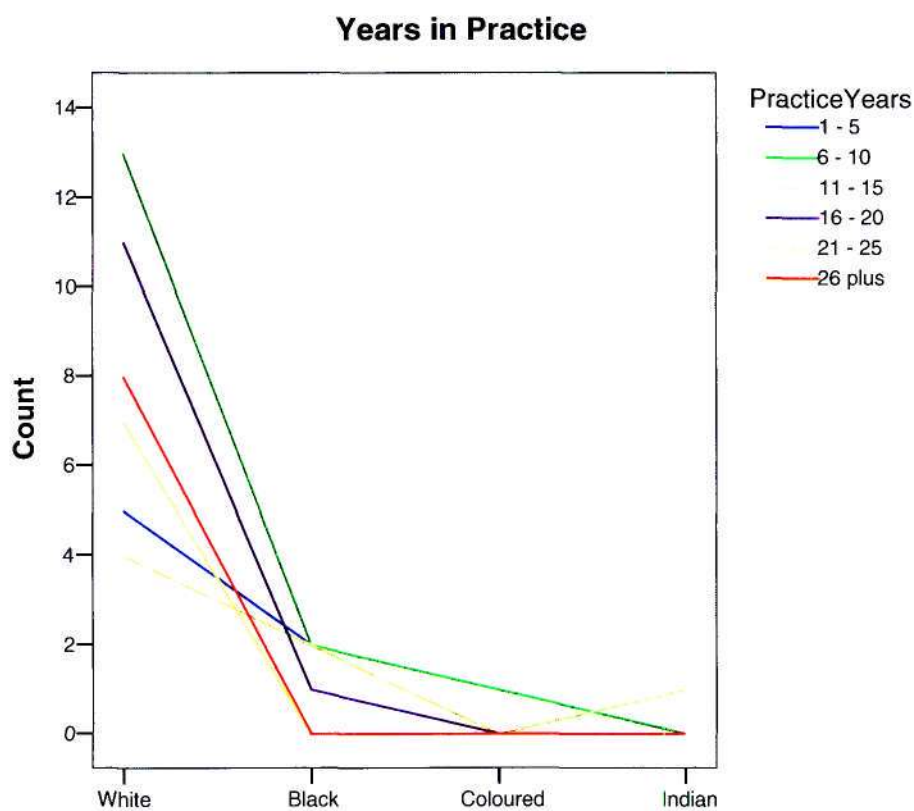


Moreover, from Figure 3 it can be seen that when race is cross-tabulated with gender, male psychologists closely followed the number of female psychologists according to

their race group. However, this pattern could not be analysed for the Coloured and Indian respondents who were represented solely by females and males respectively.

Figure 4

*Racial composition of sample by years in practice.*



From Figures 3 and 4, findings indicate the effect that Apartheid has had on the training of psychologists (Mayekiso, Strydom, Jithoo & Katz, 2004), as in this sample White psychologists dominate the field enormously. Of import, the residual effects of an exclusionary educational system continue to be evident in the last 10 years whereby Black, Indian and Coloured psychologists' numbers significantly trail those of White

psychologists. Recent published research indicates that approximately 18% of currently registered South African psychologists are Black, with White psychologists representing 82% of the whole (HPCSA 2004 records cited in Duncan, Van Niekerk & Townsend, 2004). Unfortunately, comparisons are difficult to make with this data set as it is not known what percentage of Duncan et al.'s sample were registered as clinical psychologists. Overall however, the racial profile of this sample corresponds with theirs. However, it goes without saying that these findings are not only lamentable, but are in sharp contrast to the current South African population, where proportions of the different population groups are 9.2% for Whites, 79.5% for Blacks, 2.5% for Indians, and 8.9% for Coloureds (Statistics South Africa, 2006). Therefore, in contrast to South Africa's population, this sample's race representation is inverted.

Table 5

*Cross-tabulation of gender by highest degree obtained.*

Gender	Degree				Total
	Masters	PhD			
	<i>n</i>	%	<i>n</i>	%	
Male	17	26	12	18.7	29
Female	29	45	4	6	33
Total	46	72	16	25	62
Missing	2				
Total	64				

*N* = 64

The respondents' qualifications revealed that 72% had the required minimum of a Masters degree in clinical psychology and 25% had PhD degrees (see Table 5). Thus, although all respondents had a Masters degree, male respondents were three times more

likely to have PhDs than women. It was not ascertained whether the PhDs were in psychology, however.

Table 6

*Frequencies of year in which highest degree was obtained.*

		Year obtained degree	Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1958		1	1.6	1.6	1.6
	1974		1	1.6	1.6	3.2
	1978		1	1.6	1.6	4.8
	1980		3	4.7	4.8	9.7
	1981		3	4.7	4.8	15
	1983		2	3.1	3.2	18
	1984		2	3.1	3.2	21
	1985		1	1.6	1.6	23
	1986		3	4.7	4.8	27
	1987		4	6.3	6.5	34
	1988		1	1.6	1.6	35
	1990		2	3.1	3.2	39
	1991		1	1.6	1.6	40
	1992		1	1.6	1.6	42
	1993		4	6.3	6.5	48
	1994		3	4.7	4.8	53
	1995		3	4.7	4.8	58
	1996		1	1.6	1.6	60
	1997		3	4.7	4.8	65
	1998		5	7.8	8.1	73
	1999		3	4.7	4.8	77
	2000		4	6.3	6.5	84
	2001		4	6.3	6.5	90
	2002		2	3.1	3.2	94
	2005		3	4.7	4.8	98
	2006		1	1.6	1.6	100
	Total		62	97	100	
Missing	System		2	3.1		
Total			64	100		

The mean year in which this sample graduated with their highest degree was 1992, with a median score of 1994 and a modal value of 1998 (see Table 6). The range of years between the oldest and most recent graduation was 48 years (SD = 9.04 years).

Table 7

*Frequency representation of graduating universities (ranked).*

	University	Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Pretoria	9	14.1	14.5	14.5
	Rhodes	7	10.9	11.3	25.8
	WITS	5	7.8	8.1	33.9
	UCT	5	7.8	8.1	42
	Stellenbosch	5	7.8	8.1	50.1
	OFS	5	7.8	8.1	58.2
	UNISA	4	6.3	6.5	64.7
	UKZN (Westville)	4	6.3	6.5	71.2
	RAU	4	6.3	6.5	77.7
	UPE	3	4.7	4.8	82.5
	United States	2	3.1	3.2	85.7
	North West	2	3.1	3.2	88.9
	UKZN (PMB)	2	3.1	3.2	92.1
	Zululand	1	1.6	1.6	93.7
	UWC	1	1.6	1.6	95.3
	Potchefstroom	1	1.6	1.6	96.9
	MEDUNSA	1	1.6	1.6	98.5
	Johannesburg	1	1.6	1.6	100
Missing	Total	62	96.9	100	
	System	2	3.1		
Total		64	100		

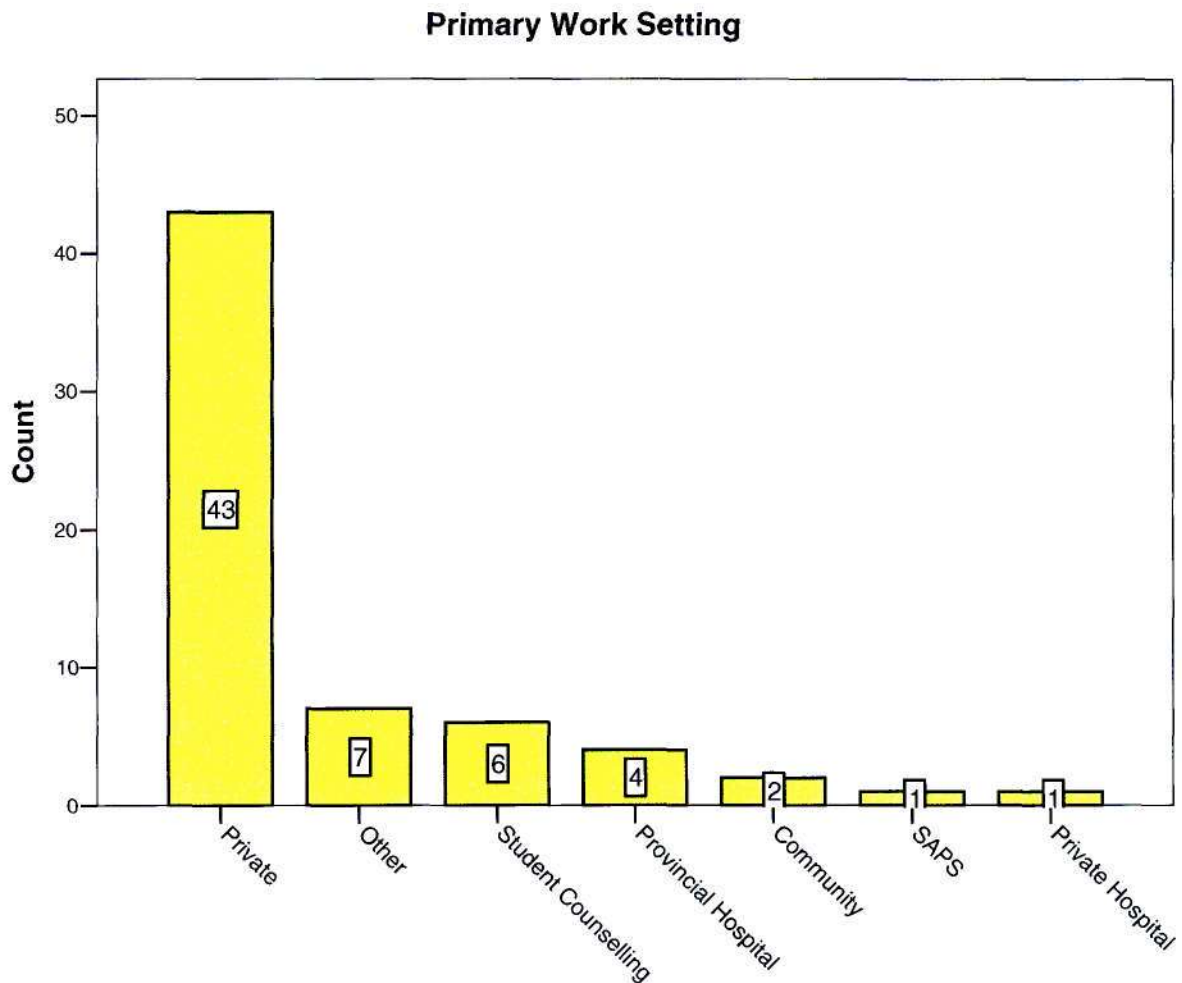
*N* = 64

Table 7 depicts the universities from which the sample graduated with their highest degree. Most of the respondents graduated from Pretoria, followed in rank order by Rhodes, with ties between UCT, WITS and the University of the Orange Free State. Two respondents obtained their highest qualification in the United States of America. The data suggests that the sample reflects a reasonable spread of South Africa's training universities, although no data was available against which representative proportionality could be determined.

Although respondents were asked to indicate only their primary work setting and therapeutic orientation (Figures 5 and 6 respectively), it became clear that most of the sample selected several of the options available to them. In order to avoid double counting the data because psychologists selected more than one option for primary work setting, only the setting indicated by the participant where most work was derived from was selected. Those who selected more than one option for their primary therapeutic orientation were coded as 'eclectic'.

Figure 5

*Number of psychologists by primary work settings.*

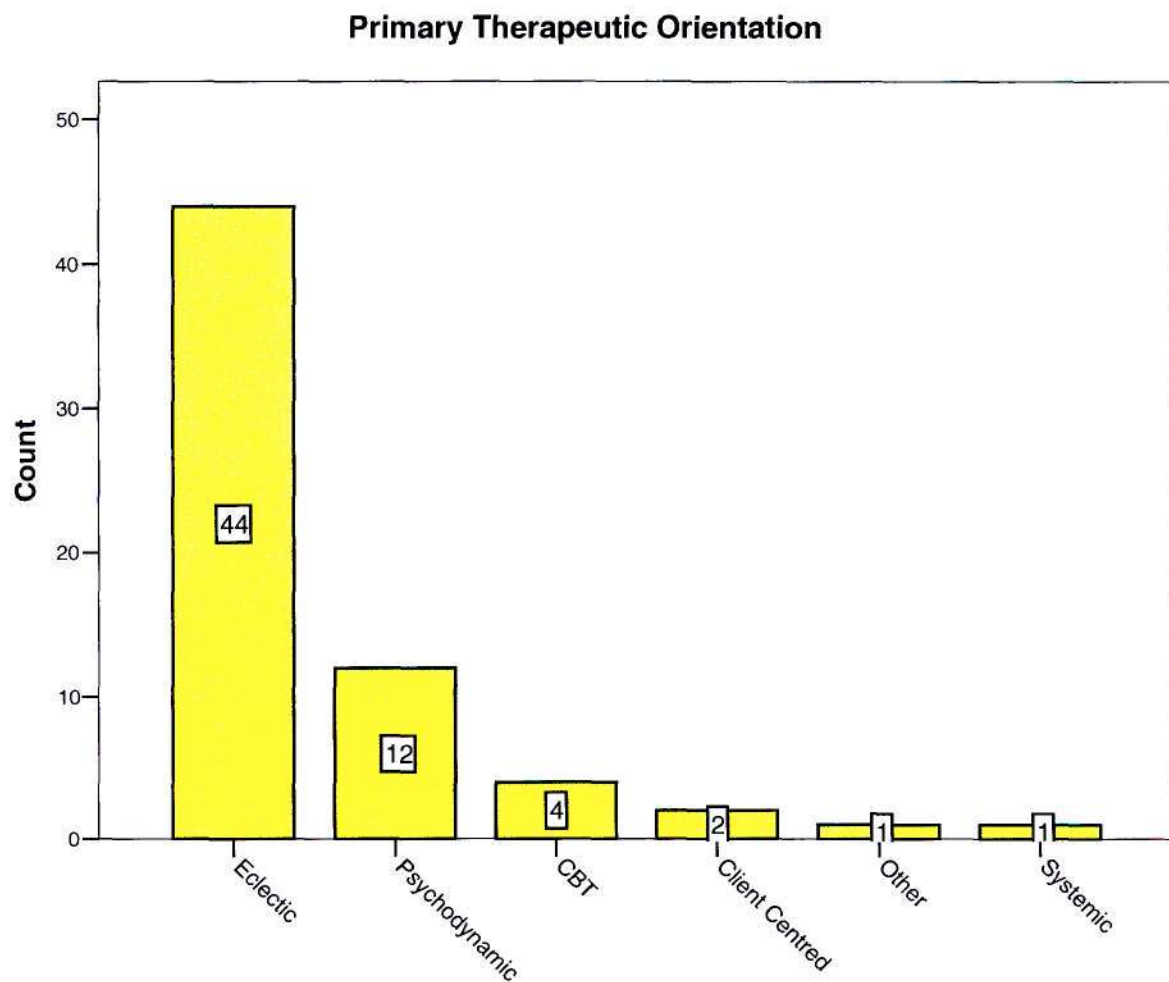


Not unexpectedly, Figure 5 demonstrates that private practice far outweighed any other work setting at a percentage of 67.2%. This is similar to Louw and Allan's (1998) findings for forensic psychologists wherein private practitioners accounted for two thirds of their sample. The next most common area of practice was 'other' at 11%. However, no specification was requested/made as to what this entailed. Student Counselling closely followed 'other' at 9%. Other areas of practice were: provincial hospital at 6%,

community at 3%, and the South African Police Service and private hospital both at 1.6%. No participant selected 'academic' as their primary work setting, although some respondents indicated that this formed part of their professional responsibilities.

Figure 6

*Number of psychologists using the following modes of therapy.*



In terms of therapeutic orientation (Figure 6), the eclectic mode (69%) was followed by psychodynamic therapies (19%) representing just over a quarter of the respondents and



cognitive behavioural therapy at 6% of the sample. Client Centred, 'Other' and Systemic were poorly represented in this sample at 3%, and 1.5% respectively.

Statistically significant correlations were found. Those who worked in the field marked "other" had less practice years experience ( $r = -0.256, p < 0.05$ ) than other work settings. Those experienced in criminal cases were more likely to be found working for Student Counselling Centres ( $r = 0.302, p < 0.05$ ). An explanation for the prevalence of practitioners working in Student Counselling Centres having processed more criminal cases may be that part of their professional responsibility is as academic psychologists. Those who worked in private practice were less likely to practice Client Centred therapies ( $r = -0.257, p < 0.05$ ) in contrast to those working in Provincial Hospitals ( $r = 0.325, p < 0.05$ ) and Student Counselling Centres who seemed to favour this approach ( $r = 0.250, p < 0.05$ ). Practitioners working in the Provincial Hospital realm approached significance in being less likely to practice eclectic therapies ( $r = -0.244, p < 0.05$ ).

#### **4.2 RELIABILITY OF IDA-R SCALE**

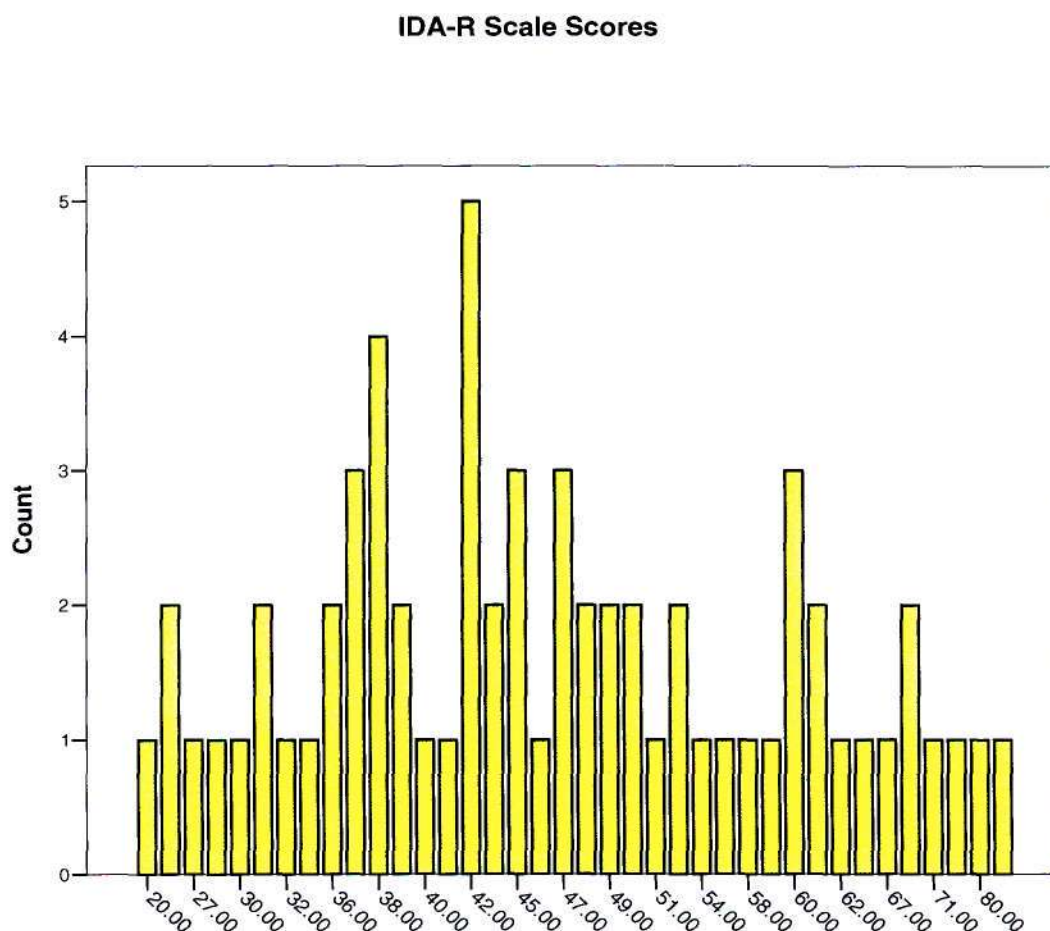
Although no reliability data could be found in Skeem and Golding's (2001) original publication, a reliability coefficient was tabulated on the 32 point IDA-R scale. The IDA-R scale produced a Cronbach's Alpha of 0.495 which is a disappointingly low reliability coefficient for social science research (Durrheim, 1999c).

### **4.3 RESEARCH QUESTION ONE**

This section explored whether clinical psychologists would differ in their opinions of the insanity defence as measured by the IDA-R scale scores for each individual (Skeem & Evans-DeCicco, 2004). The variable addressed in this section was the individual aggregate IDA-R scale score. Respondents were asked to complete a Likert scale questionnaire which consisted of 32 statements about the insanity defence, mental illness and criminal responsibility. They were given 7 response choices which ranged on a continuum from strongly disagree to strongly agree (see Appendix B). Moreover, the final question asked if the respondent had any difficulty completing the questionnaire because they could not “conceive of anyone who would not be responsible for their criminal actions” (p. 186). Each questionnaire was allocated a score between 17 and 119 derived from the scoring key developed by the authors.

Figure 7

*Overall representation of aggregate individual Insanity Defence Scale Scores.*



The IDA-R scale scores<sup>3</sup> are depicted in Figure 7. All except one respondent had no trouble completing the scale because they could not conceive of a person not being held responsible for their actions.

<sup>3</sup> If one takes the midway point between the IDA-R scale score's lower (17) and upper (119) limits, the average score obtainable is 68. In order to establish cut-off points for interpretation of the scores, this study assumes that on a continuum, scores above 68 denote low support for the insanity defence, graduating toward negative opinions. Scores between 17 and 37 denote strong support for the defence, scores between 38 and 47 demonstrate moderate support, and scores between 48 and the midpoint of 68 suggest some ambivalence about the defence.

Although at first glance the overall distribution in Figure 7 is considered to be approaching a normal distribution curve, if the midway point is held at 67, this sample's opinions are negatively skewed denoting that most (90.6%,  $n = 58$ ) were generally in favour of the insanity defence.

Table 8

*Frequencies and interpretation of aggregate individual IDA-R scale scores.*

Scores	Interpretation	Frequency	Percent	Cumulative Percent
17 - 37	Strong support	15	23.4	23.4
38 - 47	Moderate support	22	34.4	57.8
48 - 68	Ambivalent support	21	32.8	90.6
69 - 87	Ambivalent opposition	6	9.5	100
88 - 97	Moderate opposition	0	100	
98 - 119	Strong opposition	0		
	Total	64	100	

$N = 64$

However, when breaking the scores down even further (Table 8), it becomes clear that 23.4% ( $n = 15$ ) strongly supported the defence, whilst 34.4% ( $n = 22$ ) are moderately in favour, and 32.8% ( $n = 21$ ) were fairly ambivalent about the insanity defence. Negative attitudes were held by 9.4% ( $n = 6$ ) of the sample. The mean, mode and median were 47.01, 42 and 45 respectively, with a range of 66 ( $SD = 13.81$ ). The measures of central tendency were clustered in the moderately favourable portion of the scale.

A statistically significant correlation was found between lower support for the insanity defence and the belief that much reform of the insanity defence was needed ( $r = .256$ ,  $p < 0.05$ ).

Thus, although this sample showed a broad range of opinions about the insanity defence, the majority were in favour, with a small percentage exhibiting negative views. However, it should be noted that the range of the scale scores was broad, ranging between 20 and 86. Not unexpectedly, respondents who showed less support for the insanity defence also felt that it needed to be reformed.

#### 4.4 RESEARCH QUESTION TWO

This section inquired whether there would be a significant association between individual aggregate IDA-R scale scores and the demographic variables of gender, race or age.

Respondents were asked to complete a demographic data sheet attached to the IDA-R questionnaire. The data sheet requested details on gender, race and age as part of the exploratory aims of this research. The first variable to be considered was gender.

Table 9

*Mann-Whitney U Test between gender and IDA-R scale scores.*

	IDA-R Scale Scores
Mann-Whitney U	323.500
Wilcoxon W	758.500
Z	-2.188
Asymp. Sig. (2-tailed)	.029*

a Grouping Variable: Gender

\*  $p < 0.05$

$N = 62$

Table 10

*Mann-Whitney U Test mean ranks of IDA-R scale scores by gender.*

Gender	<i>n</i>	IDA-R Scale Scores	
		Mean Rank	Sum of Ranks
Male	29	26.15517241	758.5
Female	33	36.1969697	1194.5
Total	62		

*N* = 62

The Mann-Whitney U test was used to compute the IDA-R scale scores by gender. As can be deduced from Table 9, there was a statistically significant gender difference in perceptions of the insanity defence, with *z* at -2.188 and *U* at 323.500 measured at an alpha level of 0.05. Moreover, this test showed that the sum of average ranks for female psychologists' IDA-R scale scores was greater than for male psychologists (see Table 10).

Having considered the association between gender and the IDA-R scale scores, race will now be examined.

Table 11

*Chi-Square Test between race and IDA-R scales scores.*

	Race Group	IDA-R Scale Scores
Chi-Square(a,b)	103.867	20.313
Df	3	37
Asymp. Sig.	.000	.988

a 0 cells (.0%) have expected frequencies less than 5. The minimum expected cell frequency is 15.0.

b 38 cells (100.0%) have expected frequencies less than 5. The minimum expected cell frequency is 1.7.

*p* < 0.05

Race by IDA-R scale scores were tabulated using the Chi-Square test for nominal data depicted in Table 11. Bearing in mind that the Coloured and Indian samples had frequencies less than 5, no significant associations between any of the race groups' opinions about the insanity defence were found.

Table 12

*Means, standard deviations and ranges of IDA-R scale scores by gender and race.*

Race Group	Male				Female			
	Mean	<i>n</i>	SD	Range	Mean	<i>N</i>	SD	Range
White	43.61	23	16.16	86	50.76	25	15.11	60
Black	40.33	3	4.16	8	48	4	19.41	38
Coloured					44.5	2	7.77	11
Indian	37	2	1.41	2				
Total	44.37	27	12.38	59	50	31	15.01	60

*N* = 58

For the purposes of the exploratory nature of this research, Table 12 further examined the data by breaking down the individual aggregate IDA-R score composition by race and gender. Measures of central tendency demonstrate that female psychologists as a whole, regardless of race, supported the insanity defence less than their male cohorts. Here the mean score for female psychologists was 50 (SD = 15.01) denoting favourable, but fairly ambivalent attitudes. Moreover, within this group, White female clinical psychologists had the highest scores (50.76), followed in rank order by Black (48) and then Coloured (44.5) respondents, indicating that White and Black female respondents fell in the ambivalent, but supportive range, with the Coloured respondents in the moderately supportive range. Of interest, when considering male psychologists, the ordering of scores by race was replicated, albeit with slightly lower scores. An overview of these

scores demonstrates broader standard deviations and ranges, with, again, White respondents representing higher scores denoting lower support. Here mean scores for male psychologists was 43.61 for Whites, 40.33 for Blacks, and 37 for the Indian respondents. Thus, the male Indian respondents were moderately in favour of the insanity defence, with their White and Black cohorts falling in the favourable, but ambivalent range.

Having found no significant relationship between race and IDA-R scores, the association between age of respondents and IDA-R scale scores was examined.

Table 13

*Pearson Correlations between age and IDA-R Scale Scores.*

		Age	IDA-R Scale Score
Age	Pearson Correlation	1	-.110
	Sig. (2-tailed)	.	.393
	N	62	62
IDA-R Scale Score	Pearson Correlation	-.110	1
	Sig. (2-tailed)	.393	.
	N	62	64

$p < 0.05$

Pearson's  $r$  was used to measure the relationship between age and individual aggregate IDA-R scale scores. As can be seen in Table 13, this result was not found to be statistically significant. This means that age as a variable did not have any significant bearing on IDA-R scores.



In sum, this section found that gender may have some bearing on opinions towards the insanity defence. Specifically, female respondents generally supported the insanity defence less than their male counterparts, regardless of race. No significant relationship was found between race or age, and IDA-R scale scores.

#### **4.5 RESEARCH QUESTION THREE**

This section explored whether there would be a significant association between individual aggregate IDA-R scale scores and clinical psychologists' therapeutic orientation or work setting. Respondents were requested to select their primary therapeutic orientation and primary work setting on the demographic data sheet attached to the IDA-R scale questionnaire<sup>4</sup>. Respondents were given a range of choices to select for both variables, with an option for 'other' should the list not cover their primary work setting or therapeutic orientation (see Appendix A).

Separate correlation coefficients were calculated for each of the therapeutic orientations and areas of practice. Positive correlations show lack of support for the insanity defence because the higher the score, the lower the support. The first variable to be addressed is therapeutic orientation.

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<sup>4</sup> Although respondents were asked to indicate only their primary work setting and therapeutic orientation (Figures 5 and 6 respectively), it became clear that most of the sample selected several of the options available to them. In order to avoid double counting the data, where psychologists selected more than one option for primary work setting, the setting indicated by the participant where most work was derived from was selected. Those who selected more than one option for primary therapeutic orientation were coded as 'eclectic'.

Table 14

*Pearson Correlations between IDA-R scale scores and primary therapeutic orientation.*

Primary therapeutic orientation	IDA-R Scale Scores
Psychodynamic	0.253*
Systemic	-0.047
CBT	-0.209
Client Centred	0.031
Eclectic	-0.132
Other	0.109

\*  $p < 0.05$

$N = 64$

It can be seen from Table 14 that respondents who practiced psychodynamic therapies showed statistically significantly less support for the insanity defence. However, the correlation was relatively weak.

Table 15

*Means, medians and standard deviations of IDA-R Scale Scores by primary therapeutic orientation.*

Primary therapeutic orientation	Mean	Median	$n$	SD
Psychodynamic	54.33	52	12	15.68
Systemic	42	42	1	.
CBT	36	36	4	9.01
Client Centred	49.5	49.5	2	14.84
Eclectic	45.88	43	44	13.2
Other	59	59	1	.

$N = 64$

Scrutiny of the IDA-R mean and median scores by therapeutic orientation (Table 15) showed that those practicing CBT strongly supported the insanity defence. Those who

chose eclectic and systemic therapies as their primary modality scored within the moderate support range. Those practicing client centred and psychodynamic therapies were found to be in the ambivalent, but favourable range.

Having considered the possible relationship between therapeutic orientations and IDA-R scale scores, primary areas of practice will now be considered.

Table 16

*Pearson Correlations between IDA-R scale scores and primary work setting.*

Primary work setting	IDA-R Scale Scores
Private Practice	0.151
Community setting	-0.087
Hospital - Provincial or Government	-0.077
Hospital – Private	-0.185
University/College Counselling Centre	-0.030
South African Police Service	0.183
Other	-0.090

$p < 0.05$

$N = 64$

When considering the IDA-R scale score by primary work setting no significant results were found when using Pearson correlations, demonstrating that no relationship was established between work setting and strong opinions about the insanity defence (Table 16).

Table 17

*Means, medians and standard deviations of IDA-R Scale Scores by primary work setting.*

Primary work setting	Mean	Median	N	SD
Private Practice	48.55	45	43	14.41
Community setting	40.5	40.5	2	13.43
Hospital - Provincial or Government	43	44.5	4	14.3
Hospital – Private	27	27	1	.
University/College Counselling Centre	45.83	45.5	6	12.78
South African Police Service	67	67	1	.
Other	43.57	39	7	9.58

N = 64

Table 17 sets out the mean and median IDA-R scale scores by primary work setting in order to illustrate the direction in which opinions lay. Results indicate that for the SAPS respondent, there was ambivalent support for the insanity defence, just falling within the favourable range. Conversely, the sole respondent working in the private hospital setting scored in the strong support category. Those respondents working in community, provincial hospitals and ‘other’ settings were moderately supportive of the insanity defence. The bulk of respondents representing private practice fell within the lower parameters of ‘ambivalent support’. However, these findings show that, bar the SAPS and private hospital respondents, the mean and median scores were relatively similar, falling in the moderate support to ambivalent range, although with broader standard deviations.

In brief, these results show that, albeit with weak but significant correlations, practitioners of psychodynamic therapies had less support for the insanity defence than their non-psychodynamic colleagues. For the work setting variable, no statistically

significant relationship was found between any of the primary work settings and opinions about the insanity defence.

#### 4.6 RESEARCH QUESTION FOUR

This section explored whether there was a significant association between IDA-R scores and clinical psychologists who had more practice experience, forensic experience and who had processed more criminal cases. Respondents were requested to complete this information on the data sheet attached to the IDA-R questionnaire (Appendix A). These three variables have been grouped under the heading of experience and are addressed below.

Table 18

*Pearson Correlations between IDA-R scale scores and experience.*

Experience	IDA-R Scale Scores
Years in practice	-0.095
Years of forensic experience	-0.189
Numbers of criminal cases processed	0.091

$p < 0.05$

$N = 64$

The Pearson  $r$  correlations (Table 18) did not field any statistically significant scores in terms of this sample's experience, demonstrating no strong opinions for or against the insanity defence by those with more professional experience.

In sum, this section attempted to establish a relationship between individual aggregate IDA-R scale scores and experience in psychological or psycholegal practice. The results show no statistical relationship between opinions about the insanity defence and practice and forensic experience, or number of criminal cases processed.

#### **4.7 INCIDENTAL QUALITATIVE ASPECTS OF THIS RESEARCH**

Without being solicited, 14 (22%) of the respondents added hand-written comments on their questionnaires. Of these, 8 were women and 6 were men. This was an unanticipated source of qualitative information for this study. A description of the comments is included to augment the quantitative results.

One respondent who had much practice (25 years) and forensic experience (20 years) and had processed many forensic cases ( $n = 150$ ) stated the following:

For the insanity defence to work we need:

- (1) Adequate mental health facilities for referral. Current state mental health facilities are very poor, poorly staffed, inadequate 'meds' etc. Without this follow through, is [as] good as incarceration i.e. no effective treatment?
- (2) Legal system also needs to function effectively – long time awaiting trial likely to increase incidence of mental illness.
- (3) There is inadequate understanding of fundamental points of M'Naghten Rule among mental health professionals and specialist evidence.

These sentiments were reinforced by another respondent who noted that “lack of sufficient state facilities forces psychiatric personnel to discharge patients despite their professional belief that more care is needed”. This underscores a different comment which stated that there “was room for improvement” of the insanity defence, and that “not many but some” mental health professionals were irresponsible in discharging

potentially dangerous patients. Moreover, it was noted by one of the younger female respondents that “[t]his questionnaire does not discuss rehabilitative care for those who meet the criteria for ‘insanity’ but should still be held accountable. The problem is that in a country lacking resources and facilities of care we are stuck in a deadlock of insanity release versus prison” (sic).

Another female psychologist stated:

While completing this, I thought of people suffering from severe psychotic disturbances and think that the defense is important for these people.

I would not view certain Personality Disorders (eg. Anti-social or Borderline) with the same empathy or sympathy in terms of the sanity defence (sic).

Some respondents ( $n = 10$ ) equivocated over some questions adding comments as qualifying statements to their response. These comments raised the possibility of sane killers abusing the insanity defence to their own advantage. Of interest, one qualifying statement inferred that mental health practitioners in private practice were more likely to invent a mental illness to facilitate a successful insanity plea. Another argued that lawyers “in some cases” encourage their clients to lie to appear insane. Another questioned whether lack of responsibility for taking medication may aggravate as opposed to mitigate criminal capacity.

Some of the annotated comments ( $n = 5$ ) related to complaints about the IDA-R scale being “extremely limited” and the questions being ambiguous and the “objectionable” use of language such as “crazy”. Furthermore, another criticism was that some

respondents felt they did not have the requisite statistics or experience to give an informed answer.

Some respondents ( $n = 3$ ) pointed out that research employing the use of a questionnaire without opportunities for qualitative comments “simplifies” the responses and did not allow for “in-depth views” or “real discussion of the issue”. Other methodological criticisms related to some questions having more than one variable ( $n = 2$ ). Another respondent found it difficult to complete the questionnaire because it had “very loaded questions and it is extremely difficult to generalize without a case at hand”.

A valid criticism of the demographic data sheet was that the researcher did not qualify what was meant by ‘number of criminal cases processed’ whereby a respondent had “seen 100+ forensic orientated cases” and was not sure if these qualified.

Six of the respondents wished the researcher success in her endeavours.

#### **4.8 SUMMARY OF RESULTS**

Overall, 12.8% of the 500 psychologists canvassed responded to this survey. This is considered a disappointingly low response rate (Yammarino et al., 1991).

This sample of clinical psychologists ( $N = 64$ ) was almost equal with respect to gender.

There were however great disparities in terms of race, with White psychologists representing the majority of the respondents. Although, this is in line with recent HPCSA



statistics on registered psychologists by race group (Duncan et al., 2004). The average age of this sample was 48 years, with most respondents graduating in 1992. The University of training most cited was Pretoria followed by Rhodes University. Moreover, male psychologists were three times more likely to have a PhD than female psychologists.

Professional experience was measured in terms of years in practice, years of forensic experience and number of criminal cases processed. Broad ranges were evident, with mean years for practice years and forensic years, 15.17 years and 6.42 years respectively. Whereas 39% ( $n = 25$ ) of the sample had not processed any criminal cases, only 7% ( $n = 5$ ) had experience with over 100 cases. The respondent who had processed the most cases ( $n = 1000+$ ) was a female clinical psychologist.

In terms of therapeutic orientation, most practiced eclectic modalities, followed by psychodynamic therapy. The primary work setting was private practice, followed by 'other' which was not specified.

The reliability coefficient of the IDA-R scale was found to be 0.495 (Cronbach's Alpha). This is considered to be relatively low reliability for social science research (Durrheim, 1999c).

The range of IDA-R scale scores was broad (66) with individual aggregate scores ranging from 20 to 86. Although most respondents were in favour of the insanity defence, whilst

32.8% had relatively ambivalent opinions. Results exploring the relationship between IDA-R scale scores and gender suggest that female psychologists showed less support for the insanity defence than the male respondents. However, this result needs to be confirmed by a much larger sample to verify that they are not the result of chance.

No statistically significant relationship was found between opinions about the insanity defence and the demographic variables of age, race and primary work setting. A statistically significant but weak correlation was found between respondents who practiced psychodynamic therapy and low support for the insanity defence. No relationship was found between the IDA-R scale scores and those who had more practice and forensic years, or who had processed more criminal cases. However, it is recognised that more research is needed to verify these results.

Having presented the results of this research, the implications and limitations of these findings will be discussed in the next section.

## **CHAPTER FIVE**

### **DISCUSSION**

Despite methodological shortcomings, several subtle findings were extrapolated from this study. However, it should be noted that since no previous research could be found on psychologists' opinions of the insanity defence some difficulty was encountered in relating the findings to the literature.

#### **5.1 An overview of the IDA-R scale scores**

The distribution of this sample's individual aggregate IDA-R scale scores warrants the following comments. Firstly, the reliability of the scale was shown to be poor in this sample. No reliability data could be ascertained from the authors of the scale on their original sample. Considering that this scale was designed for the lay public, the author anticipated pronounced negatively skewed results depicting clear support for the insanity defence. However, the findings show an approximated normal distribution curve, albeit leaning slightly toward the lower end of the scale scores, and thus support for the insanity defence. Consequently, although the prediction that clinical psychologists would be supportive of the insanity defence was borne out by the overall findings, the broad range in scale scores was unanticipated. These results demonstrate that this sample's continuum of opinions may overlap that of the lay public (Skeem & Golding, 2001), albeit skewed more positively to the defence. Nevertheless, it could be argued that the range of this sample's clinical psychologists' opinions points to some ambivalence about the insanity defence.

Skeem and Golding (2001) cite research which demonstrates that the lay public have intuitive as opposed to accurate understandings of the legal definition of insanity. This assertion, viewed in conjunction with Allan and Louw's (2001) research on psychologists' lack of knowledge and experience in the forensic setting, may be an explanation for this sample's moderate to ambivalent supportive opinions of the insanity defence. Indeed, this was exemplified by one participant who found it difficult to complete the questionnaire because of his/her own lack of knowledge about the insanity defence. Moreover, putative abuse of the insanity defence by 'sane' criminals and members of the legal and mental health professions found quite strong expression in the annotated comments. Thus, it may be inferred that this sample's relatively broad range of opinions are not only similar to lay public opinion, but possibly erroneous regarding the perceived misuse of the defence.

#### **5.1.2 IDA-R scale scores and the demographic variables of gender, race and age**

Race and age were not found to be statistically associated with opinions of the insanity defence. When considering gender, the results suggest that female psychologists supported the defence less than the male respondents.

That female psychologists' scores leant in a negatively biased direction is noteworthy because it broadly corresponds with Skeem and Golding's (2001) findings. A possible explanation for the slightly higher scores for women is located in research by Wahl (1995) and Ryan (1998) who explored the correlates between gender and crime (cited in Skeem & Golding, 2001). Their aggregate findings suggest that women as a group feel

vulnerable because the media depict women not only as targets, but victims of violent crime, particularly at the hands of ‘madmen’. Indeed, in terms of prototype theory, it has been established that personal opinions are predicated on individual life experiences (Kempton, 1981, cited in Skeem & Golding, 2001). Thus, taking into account that this was a South African sample, more than likely familiar with violent crime, prototypes will plausibly be negatively biased.

Skeem and Golding’s (2001) research into jurors’ perceptions of insanity provides this study with important pointers around the unfeasibility of individuals having impartial attitudes toward the insanity defence, insanity *per se* and crime. Clinical psychologists, as with Skeem and Golding’s sample, will have their own “experience-based ‘knowledge structures’” which will inform their opinions and thus are not blank slates (2001, p. 561). Moreover, clinical psychologists come from a broad mix of backgrounds and experience which facilitates their knowledge and understanding in their professional field, and likewise informs their worldview.

### **5.1.3 IDA-R scale scores and primary work setting, and therapeutic orientation.**

Results seeking a relationship between primary work setting and opinions about the insanity defence were not statistically significant. This was also the case for relationships between opinions of the insanity defence and primary therapeutic orientation, except for those practicing psychodynamic therapies where a weak but statistically significant correlation was found.

From an exploratory point of view the general leaning of mean scores warrants the following discussion. The bulk of the mean scores for primary areas of practice and therapeutic orientation fell in the 'moderate' to 'ambivalent support' range. The preponderance of scores which were not in strong support of the insanity defence perhaps highlights one of the factors tested for in the IDA-R scale, namely, lack of faith in the criminal justice system (Skeem & Evans-DeCicco, 2004). In the light of this being a South African sample, perhaps it could be argued that contextual factors contribute towards ambivalent opinions. It is indisputable that South Africa's violent crime rate is high (Dissel, 2002, cited in Cohen, 2005) and that this might have negatively biased this sample's faith in the South African criminal justice system. It has been documented that violent crime has the effect of creating feelings of vulnerability, perceptions of an unsafe world, and distrust in the general community (Herman, 1992). Additionally, the deleterious effect of vicarious trauma on psychologists through treating victims of crime is being increasingly documented (Sexton, 1999). Thus, it is not unexpected that there is a direct correlation between the severity of the trauma and its psychological impact on individuals (Herman, 1992). Moreover, the fact that this sample is qualified in the field of clinical psychology does not preclude them from being victims of crime or have experienced vicarious trauma through their clients, or having conservative or biased opinions of social issues.

An added explanation for results suggesting less support and ambivalent opinions of the insanity defence may lie in Allan and Louw (2001) and Louw and Allan's (1998) research on psychologists practicing in South Africa's forensic realm. Their findings

suggest that clinical psychologists did not have the requisite training in forensic psychology to adequately execute their duties in judicial settings. Indeed, those psychologists canvassed reported that very little of their training was focused on forensic practice. Moreover, these results may suggest a convergence with Skeem and Golding's (2001) findings that very little is known, statistically, on the use of the insanity defence, and more specifically, possible abuses by 'sane' criminals. Considering that 45 % (n = 29) of this sample had no forensic experience, a plausible explanation for ambivalent opinions of the insanity defence may be lack of experience in the forensic field and incorrect knowledge about the use and abuse of the insanity defence. However, it should be noted that the opposite was not established in this research, namely that those with forensic training and experience endorsed the insanity defence (see section 5.1.4 below).

#### **5.1.4 IDA-R scale scores and years of practice and forensic experience, and criminal cases processed**

No statistically significant result was found for those who had more experience, particularly in the forensic field, and their opinions of the insanity defence. It was anticipated that fairly strong opinions would be evident for this sub-group. This result could indicate ambivalence about the insanity defence, perhaps highlighting that in South Africa, or indeed internationally, this is a complex deliberation which denies clear cut answers. More especially, since it is expected that those with forensic experience have accurate, as opposed to intuitive, understandings of what it means to plead and be found not guilty by reason of insanity. Indeed, if psychologists working in the forensic field have ethical issues regarding indefinite institutional committal, their beliefs may not have

found expression in the IDA-R scale used. Therefore, it is considered imperative to accurately canvas, at a qualitative level, opinions regarding the entirety of the insanity defence.

#### **5.1.5 Incidental qualitative aspects**

In addition to completing the questionnaire, some (22%) of the respondents “offered unsolicited opinions on the insanity defence, mental illness, or the justice system” which unexpectedly replicated Skeem and Golding’s (2001, p. 574) research results. This suggests that just over a fifth of the respondents from this study felt quite strongly about the insanity defence. Indeed, although there were some reservations about the misuse of the defence, the general consensus of the comments suggested empathy for offenders suffering from mental illness.

Consequently, it is interesting to note that the qualitative comments on this study indicated that those who work in the criminal responsibility field feel that not only is structural reform needed, but that psychologists in general need a better understanding of forensic psychology. This concurs with Louw and Allan’s (1998) earlier research on forensic psychologists. Additionally, the reference to the concern about putative dishonesty and/or irresponsibility on the part of some mental health and legal professionals underscores aspects of the IDA-R scale which was tested for, and which perhaps should be further explored in the South African context.



## **5.2 LIMITATIONS OF THIS STUDY**

This study had several limitations. The very low response rate (12.6%) did not provide a large enough sample to be able to generalise these results with confidence. Moreover, the reliability of the questionnaire was found to be relatively low which further contributes to difficulties in generalising these results to South African clinical psychologists in general.

Additionally, although the gender of the respondents was well represented, with parity between males and females, it was poorly representative in terms of race. However, recent literature shows that the overall racial profile of psychologists has not changed much in the last 19 years (Mayekiso et al., 2004). Therefore, this sample's racial profile may roughly correspond with currently registered psychologists. However, the insanity defence is essentially about individuals who have been marginalized by their mental illness (Foucault cited in Finkel, 1988). Considering South Africa's racially inequitable past, it may have been valuable to specifically assess previously marginalized groups for their opinion (Mayekiso et al., 2004).

The cost of purchasing the latest HPCSA list of registered psychologists was considered prohibitive. Therefore, the researcher resorted to using a 2002 list she had access to. However, in the light of both the 8% return to sender rate and 12.8% response rate, a more recent list would have improved the sample size. This would not only have reduced the return to sender rate, but possibly increased the overall response by a similar percentage. Moreover, it has been found that preliminary notification and following up of respondents can greatly enhance response rates (Yammarino et al., 1991), and this

practice could have improved the response to this survey. Unfortunately, due to the limited time frame no follow up was possible to facilitate a better response rate.

Additionally, since no research has apparently been done in this area with clinical psychologists, it was difficult to construct a literature review which specifically addressed this professional population. Though more research has been done in the United States on lay people's perceptions of the insanity defence, accessing these publications was prohibitively expensive.

A limitation pointed out by some respondents was that the questionnaire was too superficial and geared more for the lay public. This indicates that it may not have been sophisticated or sensitive enough to fully capture clinical psychologists' opinions, particularly those with experience in this area. Other criticisms related to the need to include a qualitative component which would provide a study with much more depth, allowing for more nuanced and varied responses (Jackson & Van Vlaenderen, 1994). Indeed, the Likert scale is very useful in obtaining an overview of general opinions, but it is recommended that these results could be augmented with qualitative research.

Although sought from the authors, the validity and reliability of the IDA-R scale was not available for scrutiny, however when tested for in this study, reliability of the instrument was found to be relatively low.

### **5.3 MAIN CONCLUSIONS**

In conclusion, it should be noted that this study's small sample size and some confounding variables require these results to be considered with some caution, and that the generalisability of these results is tentative.

Overall, the findings show that clinical psychologists' attitudes were predominantly moderately in support of the insanity defence. This was closely followed by ambivalent support, and a smaller percentage denoting strong support. Few IDA-R scale scores were negative in opinion. Although the scale used was criticized by some of the respondents, it is noteworthy that for this sample of clinical psychologists, opinions about the insanity defence largely overlapped with those of the lay public examined by Skeem and Golding (2001). This indicates that the opinions of a proportion of this sample are likely to converge with lay opinion.

Moreover, this study's results suggest that female psychologists as a group, regardless of race, favour the insanity defence less than male psychologists. However, this should be empirically tested with a larger sample to validate whether this is an accurate reflection of female psychologists' opinions of the insanity defence, and not due to a chance result.

Possible explanations for moderate to ambivalent support for the insanity defence are various. The most likely explanation concurs with Skeem and Golding's (2001) findings of lack of knowledge about the use of the insanity defence. This underscores findings from Louw and Allan (1998) which demonstrated lack of training and forensic

knowledge on the part of South African psychologists, some of whom practice in the forensic realm. Moreover, South Africa's high crime rate may have negatively biased respondents' opinions of the criminal justice system, and by implication the merits of the insanity defence.

No relationship was established between opinions of the insanity defence and age or race variables. Moreover, no clear statistically significant result was established between opinions of the insanity defence, and primary work setting. A statistically significant result suggests that there is a correlation between those who practice psychodynamic therapies and low support for the insanity defence. However, it is recommended that this result be verified with a larger sample with more statistical power and an instrument with better reliability. No further significant results were established for the remaining therapeutic orientations.

Nevertheless, it is noteworthy that those with more practice and forensic experience did not differ significantly from those respondents who did not have the equivalent experience. This result is perplexing to the researcher, as Skeem and Golding's (2001) findings suggest that lack of forensic knowledge generally was equated with more negative opinions on the insanity defence. Therefore, this research expected to find the converse for those equipped with psycholegal experience. Thus, more in depth qualitative investigation is indicated for psychologists with forensic experience and their opinions of the insanity defence.

Considering that most of the results were rather tenuous, more focused research should be conducted in future with a larger sample to facilitate greater statistical reliability.

#### **5.4 RECOMMENDATIONS FOR FUTURE RESEARCH**

Considering that this was an exploratory study researching a topic which, to the author's knowledge, is unresearched in South Africa to date, there are several ways to improve future research into this area.

Qualitative research would enhance a more comprehensive approach to determining much more varied and nuanced aspects (Jackson & Van Vlaenderen, 1994) of clinical psychologists' attitudes about the insanity defence in the South African context.

Indeed, perhaps a validated and reliable data collection tool should be designed for future research of this topic which takes into account previous research done on South African forensic psychologists (Louw & Allan, 1998) and the South African milieu. Moreover, an up to date HPCSA list of South African registered psychologists will probably facilitate a better response rate. A better response rate would have improved the statistical power of the sample and the results established therein. Additionally, a reminder to respondents is generally reported to be effective in increasing response rates (Yammarino et al., 1991).

In the light of the results of this sample suggesting that there may be differences in opinion of the insanity defence by gender, and that opinions may differ according to

therapeutic orientation, further quantitative and qualitative research is warranted to verify and explore these results.

An avenue of future research in South Africa would be to explore differences of opinion of the insanity defence between clinical and counselling psychologists, and perhaps in contrast to psychiatrists. Moreover, it may be fruitful to replicate Skeem and Golding's (2001) research with the lay public and assess whether there are significant differences between lay public and mental health professionals' attitudes.

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## APPENDIX A

### Questionnaire.

I understand the nature and purposes of this study and am participating freely and voluntarily. I understand that by completing the anonymous questionnaire below I have indicated my consent to participate.

### Demographic details. (Please tick/complete where applicable).

Gender:

Male

Female

Age:

Race:

Under apartheid reference to race was generally seen as offensive. For this study race is a variable of academic interest only.

Years in practice:

Years of forensic experience:

Number of criminal forensic cases you have processed:

### Qualifications. (Please complete).

Highest Degree obtained	
Year obtained	
Name of University	

### Primary therapeutic orientation. (Please tick where applicable).

Psychodynamic	
Systemic	
Cognitive Behavioural	
Client Centered	
Eclectic-integrative	
Other	

### Primary work setting. (Please tick where applicable).

Private practice	
Community setting	
Hospital – Provincial or Government	
Hospital – Private	
University/College Counselling Centre	
Academic	
SAPS	
DCS	
Other	

## APPENDIX B

### Attitudes Toward The Insanity Defence (Skeem & Evans-DeCicco, 2004).

For each statement below, please ring the choice that reflects your attitude, using the scale:

**1 = strongly disagree, 2 = moderately disagree, 3 = slightly disagree,  
4 = neutral, 5 = slightly agree, 6 = moderately agree, 7 = strongly agree.**

1. I believe that people should be held responsible for their actions no matter what their mental condition.  
Strongly Disagree      1      2      3      4      5      6      7      Strongly Agree
2. It is not necessarily wrong to punish someone for something they did under the influence of irrational experiences that they could not control.  
Strongly Disagree      1      2      3      4      5      6      7      Strongly Agree
3. I do not believe that the insanity defence\* sends a message to average criminals that they can escape punishment.  
Strongly Disagree      1      2      3      4      5      6      7      Strongly Agree
4. For the right price, psychiatrists or psychologists will probably manufacture a "mental illness" for any criminal to convince the court that he is insane.  
Strongly Disagree      1      2      3      4      5      6      7      Strongly Agree
5. I believe that we should punish a person for a criminal act *only* if he understood the act as evil and then freely chose to do it.  
Strongly Disagree      1      2      3      4      5      6      7      Strongly Agree
6. I believe that all human beings know what they are doing and have the power to control themselves.  
Strongly Disagree      1      2      3      4      5      6      7      Strongly Agree
7. The insanity defence\* is a necessary element in our legal system.  
Strongly Disagree      1      2      3      4      5      6      7      Strongly Agree
8. The insanity defence\* threatens public safety by telling criminals that they can get away with a crime if they come up with a good story about why they did it.  
Strongly Disagree      1      2      3      4      5      6      7      Strongly Agree
9. Most people who are found "not guilty by reason of insanity" really are insane.  
Strongly Disagree      1      2      3      4      5      6      7      Strongly Agree
10. I believe that mental illness can impair people's ability to make logical choices and control themselves.  
Strongly Disagree      1      2      3      4      5      6      7      Strongly Agree
11. A defendant's degree of insanity is irrelevant: if he commits the crime, then he should do the time.  
Strongly Disagree      1      2      3      4      5      6      7      Strongly Agree

12. The insanity defence\* returns disturbed, dangerous people to the streets.  
Strongly Disagree      1      2      3      4      5      6      7      Strongly Agree
13. Mentally ill defendants who plead insanity have failed to exert enough willpower to behave properly like the rest of us. So, they should be punished for their crimes like everyone else.  
Strongly Disagree      1      2      3      4      5      6      7      Strongly Agree
14. As a last resort, defence attorneys will encourage their clients to act strangely and lie through their teeth in order to appear "insane".  
Strongly Disagree      1      2      3      4      5      6      7      Strongly Agree
15. Severe mental illness suggests a reduced ability to make wise decisions, to form criminal intents, and to act in accordance with the law.  
Strongly Disagree      1      2      3      4      5      6      7      Strongly Agree
16. Perfectly sane killers can get away with their crimes by hiring expensive lawyers and experts who misuse the insanity defence\*.  
Strongly Disagree      1      2      3      4      5      6      7      Strongly Agree
17. The insanity plea is a loophole in the law that allows too many guilty people to escape punishment.  
Strongly Disagree      1      2      3      4      5      6      7      Strongly Agree
18. The insanity defence\* should be abolished.  
Strongly Disagree      1      2      3      4      5      6      7      Strongly Agree
19. Most insane offenders are released from custody only when they no longer pose any significant threat of harm.  
Strongly Disagree      1      2      3      4      5      6      7      Strongly Agree
20. We should punish people who commit criminal acts, regardless of their degree of mental disturbance.  
Strongly Disagree      1      2      3      4      5      6      7      Strongly Agree
21. It is wrong to punish people who commit crime for crazy reasons while gripped by uncontrollable hallucinations or delusions.  
Strongly Disagree      1      2      3      4      5      6      7      Strongly Agree
22. Most defendants who use the insanity defence\* are truly mentally ill, not fakers.  
Strongly Disagree      1      2      3      4      5      6      7      Strongly Agree
23. Few criminals actually "get off" by using the insanity defence\*.  
Strongly Disagree      1      2      3      4      5      6      7      Strongly Agree
24. People who do wrong may well suffer from chemical imbalances or bad parenting. But holding them responsible for their actions is the only thing that will make them behave properly.  
Strongly Disagree      1      2      3      4      5      6      7      Strongly Agree

25. Some people with severe mental illness are out of touch with reality and do not understand that their acts are wrong. These people cannot be blamed and do not deserve to be punished.  
**Strongly Disagree**      1      2      3      4      5      6      7      **Strongly Agree**
26. Many of the crazy criminals that psychiatrists or psychologists see fit to return to the streets go on to kill again.  
**Strongly Disagree**      1      2      3      4      5      6      7      **Strongly Agree**
27. With slick attorneys and a sad story, any criminal can use the insanity defence\* to wangle his way to freedom.  
**Strongly Disagree**      1      2      3      4      5      6      7      **Strongly Agree**
28. It is wrong to punish someone for an act they commit because of any uncontrollable illness, whether it be epilepsy or mental illness.  
**Strongly Disagree**      1      2      3      4      5      6      7      **Strongly Agree**
29. The insanity defence\* needs a lot of reform.  
**Strongly Disagree**      1      2      3      4      5      6      7      **Strongly Agree**
30. How strongly do you feel about the insanity defence\*?  
**Not at all**      1      2      3      4      5      6      7      **Very strongly**
31. How personally important is your opinion on the insanity defence\*?  
**Not at all**      1      2      3      4      5      6      7      **Very strongly**
32. How much do you care about the insanity defence\*?  
**Not at all**      1      2      3      4      5      6      7      **Very strongly**

Did you have trouble completing this checklist because you cannot conceive of anyone who would not be responsible for their criminal actions?

\_\_\_\_\_ **No**                      \_\_\_\_\_ **Yes**

\* The use of the term 'insanity defence' is a colloquial one. In South African courts the term is more correctly referred to as pathological criminal incapacity, or temporary non-pathological criminal incapacity.

**The authors have kindly allowed for their measure to not be copyrighted for the purposes of research.**

Skeem, J. & Evans-DeCicco, J. (2004). Attitudes toward the insanity defense. In L.S. Wrightsman, A.L. Batson, V.A. Edkins (Eds). *Measures of Legal Attitudes*. Belmont California: Thomson Wadsworth.

APPENDIX C

**School of Psychology**  
P/Bag X01 Scottsville  
PIETERMARITZBURG, 3209  
South Africa  
07 33 2605853  
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## APPENDIX C

### **School of Psychology**

P/Bag X01 Scottsville  
PIETERMARITZBURG, 3209  
South Africa  
Phone: +27 33 2605853  
Fax: +27 33 2605809



15 May 2006

Dear Colleague,

### **Invitation to Participate in Clinical Forensic Psychology Research**

The attached anonymous questionnaire forms part of a research study for the requirements of my Masters degree in Clinical Psychology. This research is interested in perceptions of clinical psychologists regarding the 'insanity defence'\* under South African criminal law and whether psychologists have firm opinions on the merits and ethics of this defence. This is an important area of research as increasingly clinical psychologists are being called upon to assist the courts in forensic matters. Although Section 77 of the Criminal Procedures Act is fairly straightforward regarding fitness to stand trial; Section 78 is much more complicated, relating to the legal definitions and procedural aspects of the 'insanity defence'\*.

It would be much appreciated if you could assist me by completing this questionnaire which should take you about 10 minutes. Included is a postage-paid reply envelope. If you are unable to complete the questionnaire I would nevertheless be grateful if you would return the blank questionnaire and simply mark it 'incomplete'.

You have been randomly chosen from the HPCSA's list of registered clinical psychologists. No identifying markers are attached to the questionnaire and therefore data analysis will not reflect any individual submissions.

The final outcome of this study is that this dissertation will be lodged in the UKZN library at the Pietermaritzburg campus, and it is hoped that the standard will be high enough to be published in a peer reviewed journal. Should you wish to be informed of the key findings of this research, please email me the request so as not to affect the anonymity of your questionnaire.

Your contribution to this study is greatly valued. **I would be most grateful if you could complete and return the questionnaire before the 15<sup>th</sup> July 2006.**

Thanks and regards

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Ms P I Styles (Clinical Psychology Intern)  
083 482 6005 / 031-765 7831 (a/h)  
[tritonja@telkomsa.net](mailto:tritonja@telkomsa.net)

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Supervised by: Prof D R Wassenaar  
Clinical Psychologist  
[Wassenaar@ukzn.ac.za](mailto:Wassenaar@ukzn.ac.za)

\* The use of the term 'insanity defence' is a colloquial one. In South African courts the term is more correctly referred to as pathological criminal incapacity, or temporary non-pathological criminal incapacity.

## APPENDIX D

### Scoring Key: Injustice and Danger

Record your scores  
For the following:

- 1. \_\_\_\_\_
- 6. \_\_\_\_\_
- 8. \_\_\_\_\_
- 11. \_\_\_\_\_
- 12. \_\_\_\_\_
- 13. \_\_\_\_\_
- 14. \_\_\_\_\_
- 16. \_\_\_\_\_
- 17. \_\_\_\_\_
- 20. \_\_\_\_\_
- 26. \_\_\_\_\_
- 27. \_\_\_\_\_

Total: \_\_\_\_\_

Reverse the scores for the  
following (that is, change 7  
To 1, 6 to 2, 5 to 3):

- 10. \_\_\_\_\_
- 21. \_\_\_\_\_
- 22. \_\_\_\_\_
- 25. \_\_\_\_\_
- 28. \_\_\_\_\_

Total: \_\_\_\_\_

Scores can range from 17 to 119. A high score indicates negative attitudes toward the insanity defence. A lower score indicates an endorsement of the insanity defence, or a belief that the defence is working for those who need it and is not likely to be abused.

#### Comments:

The purpose of the Insanity Defence Attitudes Scale – Revised is to provide a psychometrically sound assessment of potential jurors' attitudes toward the insanity defence and to possibly provide attorneys with a useful tool to use during the voir dire process.

For the original Insanity Defence Scale, see: Skeem, J.L., & Golding, S.L. (2001). Describing jurors' personal conceptions of insanity and their relationship to case judgements. *Psychology, Public Policy and Law*, 7, 561 – 621.